

# REQUEST FOR ORDERS

## PART A - Type of Travel

- |   |   |
|---|---|
| <input type="checkbox"/> PCS (Reassignment)                         | <input type="checkbox"/> Student Education <b>(See Note 1)</b>                  |
| <input type="checkbox"/> PCS (RIF, Base Closure, Unit Deactivation) | <input type="checkbox"/> Renewal Agreement Travel <b>(See Notes 2-9)</b>        |
| <input type="checkbox"/> PCS (Separation/Retirement)                | <input type="checkbox"/> Advance Return of Family Members <b>(See Note 11)</b>  |
| <input type="checkbox"/> Other (Specify) _____                      | <input type="checkbox"/> Shipment of HHG and/or POV <b>(See Notes 9&amp;11)</b> |

## PART B - Sponsor's Information

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Current Pay Plan/Series/Grade: \_\_\_\_\_ Position Title: \_\_\_\_\_

Current Organization: \_\_\_\_\_ ZIP Code/APO: \_\_\_\_\_

Duty /Home Phone: \_\_\_\_\_ Place of Hire/Home of Record: \_\_\_\_\_

Alternate Destination(s) **(See Note 4)**: \_\_\_\_\_

Employee's dates of travel: Depart \_\_\_\_\_ Return \_\_\_\_\_

## PART C - Family Member(s) Information

Family Member Travel: ☐ Concurrent ☐ Delayed ☐ Early Return

Family Member Travel: from \_\_\_\_\_ to \_\_\_\_\_  
(City & State of Residence) City & State

Student Travel: ☐ One Way Originating in: ☐ CONUS ☐ Overseas

Student Travel: from \_\_\_\_\_ to \_\_\_\_\_

Current enrollment period (dates): from \_\_\_\_\_ to \_\_\_\_\_

Family Member Name(s) (Last, First, MI)	Passport Number	Birth Date (See Note 6)	Relationship	Travel Dates (Depart/Return) (See Note 5)
_____	_____	_____	_____	-
_____	_____	_____	_____	-
_____	_____	_____	_____	-
_____	_____	_____	_____	-
_____	_____	_____	_____	-

## PART D - PCS Information

Gaining Organization & Address: \_\_\_\_\_

Reporting date: \_\_\_\_\_ New Position Title, Series, Grade: \_\_\_\_\_

## PART E - Other Shipment Information

Shipment of Private Owned Vehicle (POV): ☐ Yes **(See Note 9 & 10)** ☐ No

POV Description: \_\_\_\_\_  
(Make, Model, Year, and Serial or Chassis Number of POV)

Shipment of Household Goods (HHG): ☐ Yes ☐ No

Ship HHG from: from \_\_\_\_\_ to \_\_\_\_\_  
(City & State of Residence)

Shipment of HHG from Nontemporary Temporary Storage (NTS): ☐ Yes ☐ No

Ship NTS from: from \_\_\_\_\_ to \_\_\_\_\_

## PART F - Mode of Travel

- ☐ **Government.** I request Government transportation and understand that I must report to TMO to request a Port Call. I also understand that failure to respond to a Port Call will result in forfeiture of Government Travel entitlements for me and my family members
- ☐ **Privately Owned Vehicle (POV).** I am requesting orders for OCONUS travel and will use my POV for this purpose.
- ☐ **Commercial.** I request commercial transportation. I understand that reimbursement is limited up to the current official government rate and only when ticket(s) are purchased from the following sources and under conditions stated below:
- a. The Contract Ticket Office (CTO)
  - b. When the services of the CTO are not reasonably available, then ticketing arrangements may be secured from a branch office or general agent of an American flag carrier. Traveler must demonstrate, in writing, to the servicing finance office that the services of the CTO were not reasonably available.
  - c. When the services of the CTO are not reasonably available and ticketing arrangements cannot be secured from a branch office or general agent of an American flag carrier, the use of travel agents not under contract of the U.S. Government is authorized. Traveler must demonstrate, in writing, to the servicing finance office that the services of the CTO were not reasonably available and the ticketing arrangements could not be secured from a branch office or general agent of an American flag carrier.

## PART G - Employee Certification, Supervisor Approval and Fund Certification

1. **Employee Certification:** I certify that the information provided in this request is correct and complete to the best of my knowledge.

\_\_\_\_\_  
(Employee's Signature)

\_\_\_\_\_  
(Date)

2. **Supervisor's Approval:**

\_\_\_\_\_  
(Supervisor's Printed or Typed Name)

\_\_\_\_\_  
(Supervisor's Signature)

\_\_\_\_\_  
(Date Approved)

3. **Fund Certification:** *(Applicable only to current Army Civilians in Europe)*. Obtain from your Resource Management Office):

a. Payroll Fund Cite **(Except Student Travel)**: \_\_\_\_\_  
\_\_\_\_\_

b. Student travel Fund Cite **(Student Travel Only)**: \_\_\_\_\_  
\_\_\_\_\_

c. PCS/Separation/Retirement/Renewal Agreement Travel/Advance Return of Family Members  
Fund Cite **(Non-USAREUR Organizations only)**:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Fund Certifying Official's Signature)

\_\_\_\_\_  
(Date)

## NOTES TO REQUEST FOR TRAVEL ORDERS

**Note 1: Student Travel:** You must be eligible for a Living Quarters Allowance (LQA) or Government owned or operated quarters to request student travel orders. Current documentation showing the student is enrolled full-time must be attached to the request for orders. Documentation is required each time student education travel is requested. Secondary school (Grade 9-12) or college (undergraduate) must be located in the US (including Alaska and Hawaii). Student is authorized to ship 350 lbs. net weight of unaccompanied baggage. You must also obtain a student travel fund cite from your Resource Management Office (RMO).

**Note 2: Renewal Agreement Travel Noncumulative:** RAT entitlement is for use between consecutive periods of continuous overseas employment and may be performed between the date of completion of one agreement and before serving another tour of duty pursuant to a written agreement. Entitlement to renewal agreement travel is not cumulative from one period of service to another if not used. RAT must be performed during your window of eligibility as indicated below:

a. Initial tour (normally 36 mo.): Initial tour has a 18 month window to perform RAT. The window is 6 months prior to initial tour completion and not later than 12 months before completion of tour provided the employee has agreed to a renewal agreement tour (normally 24 mo.). In no instance will RAT be authorized if you have less than 12 months remaining on a tour.

b. Renewal tour (normally 24 mo.): Renewal tour has a 14 month window to perform RAT. The window is 2 months prior to completion of the renewal tour and not later than 12 months before completion of tour provided the employee has agreed to another renewal agreement tour (normally 24 mo.). In no instance will RAT be authorized if you have less than 12 months remaining on a tour.

**Note 3: Leave Status during Absences from Duty:** You must have approved leave from your supervisor prior to taking RAT. You may be entitled to use home leave, or leave-free travel time (use limited to 1 time per tour), or may be in a leave with or without pay status. A **copy** of your approved leave request SF 71 must be attached to this request if requesting Renewal Agreement Travel.

**Note 4: Alternate Point Destination:** RAT may be performed to a location in the 50 states and District of Columbia (DC), the Commonwealths of Puerto Rico and the Northern Mariana Island, a U.S. territory or possession, or another country in which the place of actual residence is located is located other than the location of the place of actual residence; however, an employee whose actual residence is in the 50 states and the DC must spend a substantial amount (i.e., majority) of time in the 50 states and DC, the Commonwealths of Puerto Rico and the Northern Mariana Island, a U.S. territory or possession incident to RAT to be entitled to the allowance authorized. The amount allowed for travel and transportation expenses when travel is to an alternate location shall not exceed the amount which would have been allowed for travel over a usually traveled route from the permanent duty station to the place of actual residence and for return to the same or different PDS outside CONUS as the case may be.

**Note 5: Travel in Family Unit Not Required:** You may travel alone or be accompanied by family members. Family members may travel unaccompanied but cannot perform round trip travel under renewal agreement authority if you do not perform authorized renewal agreement travel. Unaccompanied family members will not be allowed delayed use of renewal agreement authority beyond 6 months after the date you begin such travel.

**Note 6: Children Over 21 Years of Age:** If a dependent child reaches his/her 21<sup>st</sup> birthday while you are assigned to a duty station overseas, such former child is entitled to return transportation to your place of actual residence in CONUS provided his/her last travel was at Government expense as the employee family member. Travel **must** be performed when you are performing PCS travel to CONUS, separation travel or renewal agreement travel. Failure to do so will forfeit the right of travel at Government expense of the child. Travel will not be authorized once the child reaches his/her 23 birthday, you may consider returning child under early return of family member if not performing travel before the child reaches 23 years of age.

**Note 7: Transportation of Baggage:** The maximum baggage allowance that may be authorized at Government expense for you and family members returning to place of actual residence for the purpose of taking RAT will not exceed 350 lbs. for each eligible adult and 175 lbs. for each family member under 12 years of age when travel is performed by ship. When travel is performed over ocean by air the maximum baggage weight allowance that may be authorized at Government expense will not exceed 100 lbs. per person (excluding free checkable baggage) If the baggage moves as accompanied, the authorized amount will be considered as gross weight. If it is shipped as unaccompanied baggage, the authorized amount will be considered as net weight. Shipment of HHG at Government expense as baggage is prohibited in connection with RAT. Baggage allowance will be limited to personal clothing and articles necessary for the trip.

**Note 8: Renewal Agreement Travel Limitations:**

- a. Household Goods (HHG): There is no entitlement to ship HHG in connection with RAT. However, the signing of a renewal agreement in connection with RAT can be the basis for reestablishing expired entitlement for transportation of HHG and family members to extend of prior authorization that was unused.
- b. Unaccompanied Family Members: Travel entitlements for unaccompanied family members (see note 3 above).
- c. Duplicate eligibility. Duplicate transportation will not be authorized for persons who may be separately eligible of RAT as an employee and as a family member.

**Note 9: POV Shipment RAT/Replacement Vehicle:** If you plan to ship a POV from CONUS as a replacement vehicle (once every 4 years) attach a copy of your latest POV shipping document (DD Form 788). If reestablishing previously unused shipping entitlements on Renewal Agreement Travel order please provide a signed statement that you never used your POV shipping entitlements on your initial orders and have not shipped a POV overseas at Government expense.

**Note 10: POV Shipment (PCS):** If you plan to ship a foreign privately owned vehicle (FPOV) at Government expense, the FPOV must meet Department of Transportation (DOT) and US Environmental Protection Agency (EPA) standards (i.e. US Specifications).

**Note 11: Return of Family Members and HHG Prior to Return of Employee:**

1. Transportation for the return of family members and HHG prior to your return may be authorized in the following circumstances:
  - a. When you have acquired eligibility for return transportation by satisfactory completing the minimum period of service. No documentation required other than a request for orders;
  - b. When it is determined by the overseas command concerned the best interests of the Government will be serviced by the return of the family member(s) for compelling personal reason of a humanitarian or compassionate nature such as physical or mental health, death of any member of the immediate family, or obligations imposed by authority or circumstances over which the employee has no control. You must attach a copy of the commander's approval for early return of family member(s) or a command directed early return of family members.
2. If the early return of family members and/or HHG is prior to you attaining eligibility for other than the reason stated in paragraph 1a or b above, then transportation of family members and HHGs will be at the employee's expense. When eligibility is earned for return transportation at Government expense, reimbursement for the proper expense of the transportation, not to exceed the cost for transportation of the family member(s) and HHGs by the most economical route from the overseas post of duty to the place of actual residence. Paid receipt for expenses incurred will be required with the claim along with orders. Orders will not be published until attaining eligibility. If no early return of family member is involved and just shipment of HHG, then reimbursement will not be authorized until such time official orders are issued for employee's PCS or separation travel and will be limited to the cost at the time of actual return travel. Paid receipts will be required for reimbursement.
3. POV shipment is not authorized in conjunction with early return of family member(s) and/or HHG.

**SPONSORSHIP PROGRAM COUNSELING AND INFORMATION SHEET**

For use of this form, see AR 600-8-8; the proponent agency is ODCSPER

**DATA REQUIRED BY THE PRIVACY ACT OF 1974**

**AUTHORITY:** Title 5, USC Section 301.  
**PRINCIPAL PURPOSE:** Personnel service support.  
**ROUTINE USES:** To counsel soldier or civilian employee about sponsorship program entitlements, obtain a sponsorship election, and provide information to gaining battalion or activity on arrival of new members.  
**DISCLOSURE:** Mandatory. Nondisclosure may prevent participation in the sponsorship program.

1. SPONSORSHIP PROGRAM ENTITLEMENTS. *(To be used by personnel reassignments work center or civilian personnel office in counseling soldier or civilian employee about sponsorship program.)*

- a. Welcome letter
- b. A sponsor for information and help
- c. Army Community Service relocation services
- d. Greeting upon arrival
- e. Assistance with inprocessing and outprocessing
- f. Orientation to the new unit or activity and the community

2. SPONSORSHIP PROGRAM ELECTION. A sponsor will be appointed unless soldier or civilian employee initials the space below.

\_\_\_\_\_ I do not want a sponsor.

3. ARRIVAL INFORMATION TO ASSIST GAINING BATTALION OR ACTIVITY:

a. I expect to arrive at your command on/about \_\_\_\_\_  
(Month and Year)

b. My status will be (check one):

☐ Married/accompanied      ☐ Single/accompanied      ☐ Married/unaccompanied      ☐ Single/unaccompanied

c. Accompanied by family members:

NAME	AGE	SEX	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**4. LOCATOR INFORMATION**

a. CURRENT UNIT/ACTIVITY ADDRESS	b. DSN PHONE NUMBER
----------------------------------	---------------------

c. LEAVE ADDRESS AND PHONE NUMBER	d. HOME ADDRESS AND PHONE NUMBER
At this address until:	At this address until:

5. REQUEST INFORMATION ON: *(Note: If soldier or employee is being relocated near an Army Community Service Center, her or she may obtain general information such as housing, medical facilities, and schools for that area by contacting the local Army Community service.)*

I have been counseled on the sponsorship program and understand my entitlements.

TYPED OR PRINTED NAME	RANK/GRADE	SSN
MILITARY CAREER FIELD/CIVILIAN OCCUPATIONAL SERIES	SIGNATURE	DATE

**INSTRUCTIONS FOR**  
**DA 5434**  
**Sponsorship Program Counseling and Information Sheet**

The DA5434 (sponsorship form) can be downloaded from the CHRMA web site along with other inprocessing forms. In processing forms are under Living and Working Overseas. The CHRMA web site is <http://www.chrma.hqusaureur.army.mil/>

Instructions:

Part 1 - Civilian Personnel Office or Civilian Personnel Advisory Center representative briefs civilian employee. The DA 5434 is completed within three days after the employee has accepted employment. Civilians may be referred to local Army Community Service for relocation services. These are some of the key entitlements of the sponsorship program:

- a. Welcome Letter – Civilian employees receive a welcome letter from the commander of the gaining activity to which the employee is being reassigned.
- b. A sponsor for information and help – The command's sponsorship program manager assigns a sponsor to the civilian employee to help with transition to overseas environment.
- c. Army Community Service relocation services – ACS office provides welcome packets that can be mailed to the new employee prior to arrival.
- d. Greeting upon arrival – Sponsor greets new employee and/or family upon arrival in overseas area.
- e. Assistance with inprocessing – Sponsor escorts the employee to inprocessing.
- f. Orientation to the new unit or activity and the community – Sponsor introduces the newcomer to the immediate chain of command, supervisors, and coworkers; provides a tour of essential post and community locations.

Part 2 – Sponsorship Program Election

Leave blank and a sponsor will be assigned. Initial if you **do not** wish to have a sponsor assigned. Type or print name, grade, social security number, occupational series; sign and date the form.

Part 3 – Arrival Information to Assist Gaining Battalion or Activity:

- a. Insert the projected arrival date based on the travel date listed on PCS orders.
- b. Check appropriate status block.
- c. List family members on PCS orders.

Part 4 – Locator Information

- a. Provide complete current activity address.
- b. Give DSN phone number.
- c. Indicate leave address and phone number if leave is taken prior to PCS and include last date at the leave address.
- d. Provide permanent home address and include last date at this address.

Part 5 – Request Information On

Indicate request for information on housing, medical facilities, schools, etc. in this space.

Certification:

Type or print name, grade, social security number, occupational series; sign and date the form.

**Note: This form is forwarded along with employee inprocessing forms to the CPAC. The CPAC provides this form to the gaining organization's Sponsorship Program Manager.**

# **DIRECT** **DEPOSIT** SIGN-UP FORM

### DIRECTIONS

- To sign up for direct deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

**SECTION 1 (TO BE COMPLETED BY PAYEE)**

<b>A</b> NAME OF PAYEE <i>(last, first, middle initial)</i>		<b>D</b> TYPE OF DEPOSITOR ACCOUNT <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS	
ADDRESS <i>(street, route, P.O. Box, APO/FPO)</i>		<b>E</b> DEPOSITOR ACCOUNT NUMBER <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	
CITY	STATE	ZIP CODE	
TELEPHONE NUMBER AREA CODE		<b>F</b> TYPE OF PAYMENT <i>(Check only one)</i> <input type="checkbox"/> Social Security <input type="checkbox"/> Fed Salary/Mil. Civilian Pay <input type="checkbox"/> Supplemental Security Income <input type="checkbox"/> Mil. Active _____ <input type="checkbox"/> Railroad Retirement <input type="checkbox"/> Mil. Retire. _____ <input type="checkbox"/> Civil Service Retirement (OPM) <input type="checkbox"/> Mil. Survivor _____ <input type="checkbox"/> VA Compensation or Pension <input type="checkbox"/> Other _____ <i>(specify)</i>	
<b>B</b> NAME OF PERSON(S) ENTITLED TO PAYMENT		<b>G</b> THIS BOX FOR ALLOTMENT OF PAYMENT ONLY <i>(if applicable)</i>	
<b>C</b> CLAIM OR PAYROLL ID NUMBER  <div style="display: flex; justify-content: space-between;"> <span>Prefix</span> <span>Suffix</span> </div>		<div style="display: flex;"> <div style="flex: 1;">TYPE</div> <div style="flex: 1;">AMOUNT</div> </div>	
<b>PAYEE/JOINT PAYEE CERTIFICATION</b>  I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.		<b>JOINT ACCOUNT HOLDERS' CERTIFICATION</b> <i>(optional)</i>  I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.	
SIGNATURE	DATE	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

**SECTION 2 (TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)**

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS
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**SECTION 3 (TO BE COMPLETED BY FINANCIAL INSTITUTION)**

NAME AND ADDRESS OF FINANCIAL INSTITUTION		ROUTING NUMBER		CHECK DIGIT
		<div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div>		
		DEPOSITOR ACCOUNT TITLE		
<b>FINANCIAL INSTITUTION CERTIFICATION</b>				
I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.				
PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE		TELEPHONE NUMBER	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.

**THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.**

## INSTRUCTIONS FOR

### DA 5434

#### Sponsorship Program Counseling and Information Sheet

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- a elcome etter Ci ilian em loyee recei e a elcome letter from the commander of the gaining acti ity to hich the em loyee i eing rea igned  
A on or for information and hel The command on or hi rogram manger a ign a on or to the ci ilian em loyee to hel ith tran ition to o er ea en ironment
- c Army Comm nity Ser ice relocation er ice ACS office ro ide elcome ac et that can e mailed to the ne em loyee rior to arri al
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- a n ert the ro ected arri al date a ed on the tra el date li ted on CS order  
Chec a ro riate tat loc
- c i t family mem er on CS order

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- a ro ide com lete c rrent acti ity addre  
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ndicate re e t for information on ho ing medical facilitie chool etc in thi ace

Certification

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**Note: This form is forwarded along with employee inprocessing forms to the CPAC. The CPAC provides this form to the gaining organization's Sponsorship Program Manager.**

## BURDEN ESTIMATE STATEMENT

The estimated average burden associated with this collection of information is 10 minutes per respondent or record-keeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Financial Management Service, Facilities Management Division, Property & Supply Section, Room B-101, 3700 East-West Highway, Hyattsville, MD 20782 or the Office of Management and Budget, Paperwork Reduction Project (1510-0007), Washington, D.C. 20503.

## PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

## INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A, C, and F in Section 1 is printed on your government check:

- (A) Be sure that the payee's name is written exactly as it appears on the check. Be sure current address is shown.
- (C) Claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.
- (F) Type of payment is printed to the left of the amount.

United States Treasury <sup>15-51</sup>/<sub>1000</sub>

AUSTIN, TEXAS

Check No. 0000 - 4157815

Month Day Year  
08 31 84

Pay to the order of  
JOHN DOE  
123 BRISTOL STREET  
HAWKINS BRANCH, TX 76543

29-693-775 00 C

28 28  
VA COMP

DOLLARS CTS  
\$ \*\*\*\*100\*\*00

**NOT NEGOTIABLE**

@000000516 041571926

## SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

## CANCELLATION

The agreement represented by this authorization remains in effect until canceled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

## CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete the new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

## FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than \$10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

## ARMY EXCEPTIONAL FAMILY MEMBER PROGRAM EDUCATIONAL SUMMARY

For use of this form, see AR 608-75; the proponent agency is OACSIM

### DATA REQUIRED BY THE PRIVACY ACT OF 1974 (5 U.S.C. 552A)

**AUTHORITY:** PL 95-561 (*Defense Dependents' Education Act of 1978*); PL 101-476 (*Individuals with Disabilities Education Act*); PL 102-119 (*Individuals with Disabilities Education Act Amendments of 1991*); DODI 1342.12 (*Provision of Early Intervention and Special Education Services to Eligible DoD Dependents in Overseas Areas*), March 12, 1996; DODI 1010.13 (*Provision of Medically Related Services to Children Receiving or Eligible to Receive Special Education in DoD Dependents Schools Outside the United States*), August 28, 1986; 10 USC 3013; 20 USC 921 *et seq.* and 1400 *et seq.*

**PRINCIPAL PURPOSE:** To obtain information needed to evaluate and document the special education and medical needs of:

- (1) Family members of all soldiers.
- (2) Dependent children of Department of the Army civilian employees processing for an assignment to a location outside the United States where dependent travel is authorized at Government expense.

**ROUTINE USES:**

- (1) Information will be used by personnel of the military departments to evaluate and document the special education and medical needs of family members. This information will enable --
  - (a) Military assignment personnel to match the needs of family members against the availability of special education and medical services.
  - (b) Civilian personnel offices to determine the availability of special education and medically related services to meet the needs of dependent children of Department of the Army civilian employees.
- (2) Information will be used by Army Community Service in its Exceptional Family Member Outreach Program.

**DISCLOSURE:** The provision of requested information is mandatory. Failure to respond will preclude --

- (1) U.S. Total Army Personnel Command, U.S. Army Reserve Personnel Center, and Army National Guard Readiness Center from enrolling soldiers in the Exceptional Family Member Program (EFMP). Soldiers who knowingly refuse to enroll exceptional family members will receive, at a minimum, a general officer letter of reprimand. A soldier's refusal to provide information may preclude successful processing of an application for family travel/command sponsorship.
- (2) Civilian personnel offices from performing required EFMP aspects of overseas processing of Department of the Army civilian employees with dependent children with special needs. Department of the Army civilian employees who refuse to provide information will be denied the privilege of having their dependent children transported to the duty assignment outside the United States at Government expense.

### SECTION A - RELEASE OF INFORMATION

1. I release the information on the summary and in the attached reports to personnel of the military departments for the purpose of evaluating and documenting my family member's need for special education and medical services (*and for military personnel recommendations for my next assignment*).

2. SIGNATURE OF SPONSOR OR SPONSOR'S SPOUSE

3. DATE SIGNED

### SECTION B - SPONSOR INFORMATION (*please print or type*)

4. NAME (*Last, First, Middle Initial*)

5. MILITARY DEPARTMENT AFFILIATION (*Specify if Civilian*)

6. RANK OR GRADE

7. PRIMARY MOS/BRANCH/CIVILIAN  
OCCUPATIONAL SERIES

8. SOCIAL SECURITY NUMBER

9. HOME ADDRESS (*Must be a 3-line address which includes street address or P.O. Box, and Zip Code*)

10. HOME PHONE (*Include Area Code*)

11. DUTY ADDRESS (*Must be a 3-line address which includes street address or P.O. Box, and Zip Code*)

12. DUTY PHONE

a. DSN

b. COMMERCIAL (*Include area code*)

13. PROJECTED LOCATION OF NEXT ASSIGNMENT (*If known*)

14. PROJECTED DATE OF NEXT  
ASSIGNMENT

SECTION C - FAMILY MEMBER INFORMATION <i>(please print or type)</i>								
15. NAME <i>(Last, First, Middle Initial)</i>			16. SEX		17. DATE OF BIRTH <i>(DDMMYYYY)</i>		18. FAMILY MEMBER PREFIX	
<b>SECTION D - EDUCATIONAL SUMMARY</b>								
TO BE COMPLETED BY EARLY INTERVENTION PROVIDER/SCHOOL PERSONNEL. This information is used by the Department of Defense in selecting a duty station, including overseas locations, for this child's military sponsor. Please provide complete and accurate information.								
19. IS THIS STUDENT ELIGIBLE FOR EARLY INTERVENTION OR SPECIAL EDUCATION AS DESCRIBED IN INDIVIDUALS WITH DISABILITIES EDUCATION ACT? <i>(X one)</i>								
a. If "NO," do not complete the remainder of this form. Sign in block at right and return form to sponsor			SIGNATURE			DATE SIGNED		
b. If "YES," complete and sign items 19b thru 30, except for block 29.			SIGNATURE			DATE SIGNED		
20. UNDER WHAT CRITERIA IS STUDENT ELIGIBLE FOR SPECIAL EDUCATION? <i>(May only select 20a, 20b, or 20c)</i>								
a. Ages 3-21 <i>(X all that apply)</i>								
<input checked="" type="checkbox"/> (X)	CODE		<input type="checkbox"/> (X)	CODE		<input type="checkbox"/> (X)	CODE	
	N07	Autistic		N04	Mentally Retarded		N06	Orthopedically Impaired
	N02	Blind			Mild to moderate		N08	Other Health Impaired
	N11	Visually Impaired			Moderate to severe <i>(trainable)</i>		N10	Seriously Emotionally Disturbed
	N01	Deaf			Severe to profound		N12	Specific Learning Disability
	N03	Hearing Impaired		N05	Traumatic brain injury		N09	Speech Impaired
b. Birth through age 2 <i>(infants and toddlers)</i>								
<input type="checkbox"/> N13    Developmental Delay <input type="checkbox"/> N14    At Risk for Developmental Delay								
c. If student is enrolled in the Department of Defense Dependents Schools <i>(DODDS)</i> , under which criteria are they qualified for special education?								
<input type="checkbox"/> Criterion A <input type="checkbox"/> Criterion B <input type="checkbox"/> Criterion C <input type="checkbox"/> Criterion D <input type="checkbox"/> Criterion E								
21. PRESENT LEVEL OF PERFORMANCE <i>(X appropriate column to indicate student's present level in each area)</i>								
CODE			(1) No Data	(2) Normal	(3) Mild Delay	(4) Moderate Delay	(5) Severe Delay	
Q01	a. Self-Help							
Q02	b. Gross Motor							
Q03	c. Fine Motor							
Q04	d. Social							
Q05	e. Cognitive							
Q06	f. Expressive Language							
Q07	g. Receptive Language							
h. Reading and Math Grade Levels <i>(Use the following codes to indicate reading and math grade levels)</i>								
O - kindergarten    9 - 9th grade    A - 10th grade    B - 11th grade    C - 12th grade    W - preschool Y - no formal education    Z - unknown								
<input type="checkbox"/> Reading Grade Level <input type="checkbox"/> Math Grade Level								
22. SERVICES REQUIRED AND LISTED ON INDIVIDUALIZED EDUCATION PROGRAM <i>(IEP)</i> <i>(X and complete, as applicable, all services currently received)</i>								
CODE		<input type="checkbox"/> (X)	(1) Duration of Contact <i>(Minutes)</i>	(2) Frequency of Contact <i>(D, W, M, Q, Y)</i>	(3) Select Highest Level of Intensity			
					Monitoring	Consult	Direct	
S01	a. Audiology							
S02	b. Counseling							
S03	c. Occupational Therapy							
S04	d. Psychological Services							
S05	e. Physical Therapy							
S06	f. Therapeutic Recreation							
S07	g. School Health Services							
S08	h. Social Work Services							
S09	i. Speech Therapy							

23. SERVICES REQUIRED AND LISTED ON INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP) (X and complete as applicable, all services currently received)

CODE		(X)	(1) Duration of Contact (Minutes)	(2) Frequency of Contact (D, W, M, Q, Y)	(3) Select Highest Level of Intensity		
					Monitoring	Consult	Direct
F10	a. Family Training/Counseling						
F11	b. Special Instruction						
F12	c. Speech Language Pathology						
F03	d. Occupational Therapy						
F05	e. Physical Therapy						
F04	f. Psychological Services						
F13	g. Service Coordination						
F14	h. Diagnostic Medical Services						
F07	i. Health Services						
F15	j. Vision Services						
F08	k. Social Work Services						
F16	l. Assistive Technology						
F17	m. Transportation						

24. Special Transportation ☐ Wheelchair ☐ School Bus Attendant

25. Does student require wheelchair accessibility in school building? ☐ YES ☐ NO

26. Percentage of student's time spent in special education classes or resource room: \_\_\_\_\_%

27. Does student require residential treatment in order to benefit from educational program? ☐ YES ☐ NO

28. STUDENT'S SPECIAL EDUCATION SERVICE DELIVERY SYSTEM CODE (Please enter one of the following)

A - Self-contained residential placement    B - Self-contained residential placement in special school  
 C - Self-contained class in a community public school    D - Special education setting for 60 percent or more of the time  
 E - Pull-out program or resource room program    F - Co-teaching or inclusion model  
 G - Classroom teaching with technical assistance by service provider  
 H - Progress monitored by service provider

29. OTHER COMMENTS

**SECTION E - ACKNOWLEDGEMENTS**

**30. SPONSOR OR SPONSOR'S SPOUSE:**

The above information has been reviewed and found to be accurate and complete.

a. SIGNATURE

b. DATE SIGNED

**31. SCHOOL PERSONNEL**

a. TYPED OR PRINTED NAME *(Last, First, MI)*

b. TITLE

c. TELEPHONE *(Include area code)*

d. NAME OF SCHOOL

e. ADDRESS *(Include Zip Code)*

f. SCHOOL DISTRICT

g. SIGNATURE

h. DATE SIGNED

**31. FOR USE BY MEDICAL COMMAND AND ASSIGNMENT PERSONNEL ONLY**

**32. FOR USE IN THE EFMP CODING PROCESS:**

a. Special medical needs that need to be coordinated with overseas command ☐ YES ☐ NO

b. Disenrollment code *(If applicable, please enter one of the following)*

D - Death    E - Educational Condition No Longer Exists    M - Medical Condition No Longer Exists  
N - No Longer Meets Requirements    S - Separation/Retirement    V - Divorce

c. NAME OF CODER *(Last, First, Middle Initial)*

d. MEDICAL TREATMENT FACILITY CODE

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## ROTATION AGREEMENT - EMPLOYEES RECRUITED FROM THE UNITED STATES

For use of this form, see AR 690-300, chapter 301; the proponent agency is DCSPER

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This agreement must be signed by an employee recruited from the United States (*US*) for an assignment with career or career-conditional status to a Department of the Army (*DA*) position in any foreign area and the Republic of Panama. It covers employees recruited from within DA, from other Federal agencies, and from outside the Federal service. This agreement must be signed before an employee may be assigned to a position in a foreign area.

This document is an agreement between the DA and the employee named in item 1 below regarding the requirements of the DA Rotation Program. This agreement becomes effective upon the employee's initial assignment to the foreign area listed in item 2 below; it remains in effect throughout all approved extensions.

The initial period of the employee's overseas tour is shown in item 4 below. Extensions beyond the initial tour are authorized if management decides that an extension is in the best interest of DA and the employee consents to the extension. Such an extension is initiated only by management. A management decision to return the employee to the US rather than to grant an extension is not grievable by the employee. (See AR 690-700, chap 771, para 1-7b(15)).

The employee recognizes the obligation to apply for assignment to the US before completion of the overseas tour or extension(s) thereof as specified in DOD 1400.20-1-M (DOD Program for Stability of Civilian Employment Policies, Procedures, and Programs Manual). This application must be made within 7 workdays following the date of a management decision not to extend the employee's tour. DA agrees to give the employee timely notice of the requirement to apply for assignment. If notice to the employee is delayed, the employee's application may be delayed until not later than 30 calendar days after the date of the notice.

Reemployment rights (if applicable) are to the position shown in item 3 below. If the employee has reemployment rights to a position in the US at a grade equal to or higher than the one occupied 6 months before completion of the overseas tour, the employee will apply to exercise these rights. If reemployment rights are to a lower grade, the employee may either exercise these rights or register in the DOD Priority Placement Program (PPP).

When the employee does not have reemployment rights, or when these rights will not be exercised, application for return to the US will be made through the PPP. The employee agrees to expand availability to the geographic area considered necessary by the registering Civilian Personnel Office to assure receipt of one valid offer of continued employment from the US. The employee's initial availability will be for up to one full PPP Zone; this Zone will be the Zone in the US from which the employee was recruited or a Zone less distant from the overseas activity. If an offer is not received within the first 90 calendar days, the employee's availability will be expanded to at least two full PPP Zones. If an offer is not received within the succeeding 90 calendar days, the employee's availability will be expanded nationwide. The employee agrees to accept, as outlined in DOD 1400.20-1-M, the first valid offer of continuing employment made from the US. The employee will then return to the US within 30 calendar days. With the concurrence of the gaining activity in the US, this time period normally may be extended not to exceed 45 calendar days.

DA agrees to reasonably help the employee to apply for return placement in the US. Also, DA agrees to help the employee to obtain a valid offer of continuing employment which is consistent with the employee's geographic and occupational availability.

By signing at item 5 below or in the appropriate signature block item on the extension addendum, the employee agrees to the above conditions of employment and understands that failure to abide by the terms of the agreement may result in a proposal to separate the employee from the Federal service.

This agreement becomes void if, before completion of the overseas tour, the employee transfers to a Federal agency outside the Department of Defense or is voluntarily or involuntarily separated.

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**ROTATION AGREEMENT - EMPLOYEES RECRUITED FROM THE UNITED STATES** *(Cont'd)*

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1. NAME OF EMPLOYEE

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2. POSITION AND AREA FOR WHICH SELECTED

---

3. REEMPLOYMENT RIGHTS

\_\_\_\_\_ NONE

TO \_\_\_\_\_

---

4. INITIAL OVERSEAS TOUR \_\_\_\_\_ MONTHS      DATE TOUR BEGINS \_\_\_\_\_

---

5. EMPLOYEE'S SIGNATURE

---

6. TITLE AND SIGNATURE OF PERSONNEL REPRESENTATIVE

---

7. DATE OF AGREEMENT

---

**1ST EXTENSION\***

8. DATE OF APPROVED EXTENSION \_\_\_\_\_ FOR \_\_\_\_\_ MONTHS

---

9. EMPLOYEE'S SIGNATURE

---

10. TITLE AND SIGNATURE OF PERSONNEL REPRESENTATIVE

---

11. DATE OF AGREEMENT

---

**2ND EXTENSION\***

12. DATE OF APPROVED EXTENSION \_\_\_\_\_ FOR \_\_\_\_\_ MONTHS

---

13. EMPLOYEE'S SIGNATURE

---

14. TITLE AND SIGNATURE OF PERSONNEL REPRESENTATIVE

---

15. DATE OF AGREEMENT

---

**3RD EXTENSION\***

16. DATE OF APPROVED EXTENSION \_\_\_\_\_ FOR \_\_\_\_\_ MONTHS

---

17. EMPLOYEE'S SIGNATURE

---

18. TITLE AND SIGNATURE OF PERSONNEL REPRESENTATIVE

---

19. DATE OF AGREEMENT

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*\*If reemployment rights are extended, attach a completed Supplement to Reemployment Rights Agreement. (See AR 690-300, chap 352, app C.)*

**EXCEPTIONAL FAMILY MEMBER PROGRAM INFORMATION SHEET**

For use of this form, see AR 608-75; the proponent agency is OACSIM

**DATA REQUIRED BY THE PRIVACY ACT OF 1974**

**AUTHORITY:** PL 94-142 (*Education for All Handicapped Children Act of 1975*); PL 95-561 (*Defense Dependents' Education Act of 1978*); DODI 1342-12 (*Education of Handicapped Children in DODDS*), 17 December 1981; DODI 1010.13 (*Provision of Medically Related Services to Children Receiving or Eligible to Receive Special Education in DOD Dependents Schools Outside the United States*), 28 August 1986, 10 USC 3013; 20 USC 921-932 and 1401 et. seq.

**PRINCIPAL PURPOSE:** To identify the special education and medical needs of dependent children and medical needs of adult family members of Department of the Army civilian employees processing for an assignment to a location outside the United States where dependent family member travel is authorized at Government expense.

**ROUTINE USES:** Information will be used by civilian personnel offices to determine the need for coordinating the availability of medically related services to meet the special needs of dependent children and medical needs of family members of Department of the Army civilian employees processing for an assignment to a location outside the United States where dependent family member travel is authorized at Government expense.

**DISCLOSURE:** The provision of requested information is mandatory. Failure to respond will preclude--  
(1) Civilian personnel offices from performing required EFMP aspects of overseas processing of Department of the Army civilian employees with family members with special needs.  
  
(2) Transportation of family members of Department of the Army civilian employees to duty assignments outside the United States at Government expense.

**CONFIDENTIALITY:** Information obtained will be maintained in strict confidence and provided only to those with an official need to know in identifying special needs and in processing personnel for assignments outside the United States.

**PART A - GENERAL INFORMATION**

ALL EMPLOYEES TAKING AN ASSIGNMENT IN A LOCATION OUTSIDE THE UNITED STATES WHERE FAMILY MEMBER TRAVEL IS AUTHORIZED AT GOVERNMENT EXPENSE MUST COMPLETE THIS FORM. EMPLOYEES WHO DO NOT HAVE FAMILY MEMBERS MUST COMPLETE BLOCKS 1-7 AND SIGN THE APPROPRIATE CERTIFICATION STATEMENT BELOW.

1. SPONSOR'S NAME ( <i>Last, first, MI</i> )	2. SPONSOR'S SOCIAL SECURITY NUMBER
3. SPONSOR'S TITLE	4. SPONSOR'S GRADE
5.a. SPONSOR'S HOME ADDRESS	6. SPONSOR'S HOME PHONE ( <i>Include area code</i> )
5.b. SPONSOR'S DUTY ADDRESS	7. SPONSOR'S DUTY PHONE a. DSN  b. COMMERCIAL ( <i>Include area code</i> )

**PART B - FAMILY MEMBERS AUTHORIZED TRAVEL OUTSIDE THE UNITED STATES**

8. NAME ( <i>Last, first, MI</i> )	9. RELATIONSHIP	10. DOB ( <i>YYYYMMDD</i> )	11. SEX
a.			
b.			
c.			
d.			
e.			

12. PLEASE READ ALL OF THE FOLLOWING QUESTIONS VERY CAREFULLY AND SIGN THE APPROPRIATE CERTIFICATION STATEMENT IN k. BELOW.

a. DO ANY OF THE ABOVE FAMILY MEMBERS HAVE A LONG TERM (*i.e., more than one year's duration*) PHYSICAL OR EMOTIONAL ILLNESS?

b. ARE ANY OF THE ABOVE FAMILY MEMBERS BEING SEEN AT A HOSPITAL OR CLINIC REGULARLY? (*"Regularly" means about every 2 months or more often and 4 or 5 times a year or more often.*)

c. WILL ANY OF THE ABOVE FAMILY MEMBERS NEED TO BE SEEN AT A HOSPITAL OR CLINIC OUTSIDE THE UNITED STATES REGULARLY BASED ON THEIR PRESENT MEDICAL CONDITION?

d. HAVE ANY OF THE ABOVE FAMILY MEMBERS BEEN TOLD THEY SHOULD BE SEEN REGULARLY AT A HOSPITAL OR CLINIC BUT ARE NOT BEING SEEN?

e. ARE ANY OF THE ABOVE FAMILY MEMBERS ENROLLED IN A SPECIAL EDUCATION PROGRAM?

f. DO ANY OF THE ABOVE FAMILY MEMBERS HAVE A LEARNING DISABILITY?

g. ARE ANY OF THE ABOVE FAMILY MEMBERS BLIND, DEAF, OR HARD OF HEARING?

h. DO ANY OF THE ABOVE FAMILY MEMBERS HAVE A SPEECH PROBLEM THAT REQUIRES THE SERVICES OF A SPEECH THERAPIST?

i. DO ANY OF THE ABOVE FAMILY MEMBERS HAVE A PHYSICAL DISABILITY THAT COULD AFFECT THEIR LEARNING?

j. DO ANY OF THE ABOVE FAMILY MEMBERS REQUIRE PROFESSIONAL COUNSELING REGARDING PROBLEM BEHAVIOR, SUCH AS ABUSE OF ALCOHOL OR DRUGS, RUNNING AWAY, SKIPPING SCHOOL, OR OTHER DELINQUENT-TYPE ACTS?

**k. SIGN ONE OF THE CERTIFICATIONS BELOW**

(1) I CERTIFY THAT I DO NOT HAVE FAMILY MEMBERS.

(a) SIGNATURE OF SPONSOR

(b) DATE (YYYYMMDD)

(2) I CERTIFY THAT MY ANSWER TO EACH OF THE ABOVE QUESTIONS IS NO FOR EACH OF THE FAMILY MEMBERS LISTED ABOVE.

(a) SIGNATURE OF SPONSOR

(b) DATE (YYYYMMDD)

(3) I CERTIFY THAT ONE OR MORE OF MY ANSWERS TO THE ABOVE QUESTIONS IS YES REGARDING A FAMILY MEMBER LISTED ABOVE. (*Check appropriate block below*)

☐ I INTEND THAT THE FAMILY MEMBER OR FAMILY MEMBERS WILL TRAVEL WITH ME CONCURRENTLY.

☐ I INTEND THAT THE FAMILY MEMBER OR FAMILY MEMBERS WILL TRAVEL ON A DELAYED BASIS.

☐ I DO NOT INTEND THAT THE FAMILY MEMBER OR FAMILY MEMBERS WILL TRAVEL TO MY NEW DUTY LOCATION OUTSIDE THE UNITED STATES. I UNDERSTAND THAT A DA FORM 5862-R (*ARMY EXCEPTIONAL FAMILY MEMBER PROGRAM MEDICAL SUMMARY*) AND DA FORM 5291-R (*ARMY EXCEPTIONAL FAMILY MEMBER PROGRAM EDUCATIONAL SUMMARY*) (*WHEN APPLICABLE*) MUST BE COMPLETED ON THE FAMILY MEMBER OR FAMILY MEMBERS AND PROVIDED TO THE CIVILIAN PERSONNEL OFFICE SHOULD I, AT A LATER DATE, DECIDE TO HAVE THE FAMILY MEMBER OR FAMILY MEMBERS JOIN ME AND THIS MUST BE ACCOMPLISHED PRIOR TO THEIR ARRIVAL AT THE LOCATION OUTSIDE THE UNITED STATES.

(a) SIGNATURE OF SPONSOR

(b) DATE (YYYYMMDD)

**DEPARTMENT OF DEFENSE (DOD) TRANSPORTATION AGREEMENT  
TRANSFER OF CIVILIAN EMPLOYEES OUTSIDE CONUS (OCONUS)**

*(Outside the 48 Contiguous States and the District of Columbia)*

**PRIVACY ACT STATEMENT**

(5 U.S.C. §552a)

**AUTHORITY:** 5 U.S.C. §5701, §5722, §5723, §5724, and E.O. 9397 (SSN).

**PRINCIPAL PURPOSE(S):** Used to establish Government time in service requirements in order for the employee (including appointees and student trainees) to be eligible for travel and transportation expenses when transferred to positions outside the Continental United States (OCONUS).

**ROUTINE USE(S):** In addition to being used by officials and employees of the applicant's Service in determining eligibility for travel and transportation expenses, the information contained herein may be provided to law enforcement personnel investigating those suspected of fraudulently obtaining allowances.

**DISCLOSURE:** Voluntary; however, completion of this form is necessary before transfer can be authorized and expenses paid. The personal information requested is necessary to properly identify the employee.

<b>A. EMPLOYEE NAME</b> <i>(Last, First, Middle Initial)</i>		<b>B. TYPE OF AGREEMENT</b> <table border="1" style="width: 100%; border-collapse: collapse;"><tr><td style="width: 50%; text-align: center;"><input type="checkbox"/> INITIAL</td><td style="width: 50%; text-align: center;"><input type="checkbox"/> PERMANENT CHANGE OF STATION (PCS) ONLY</td></tr><tr><td style="text-align: center;"><input type="checkbox"/> RENEWAL</td><td style="text-align: center;"><input type="checkbox"/> RENEWAL IN CONJUNCTION WITH PCS</td></tr></table>		<input type="checkbox"/> INITIAL	<input type="checkbox"/> PERMANENT CHANGE OF STATION (PCS) ONLY	<input type="checkbox"/> RENEWAL	<input type="checkbox"/> RENEWAL IN CONJUNCTION WITH PCS
<input type="checkbox"/> INITIAL	<input type="checkbox"/> PERMANENT CHANGE OF STATION (PCS) ONLY						
<input type="checkbox"/> RENEWAL	<input type="checkbox"/> RENEWAL IN CONJUNCTION WITH PCS						
<b>C. EMPLOYEE SSN</b>	<b>D. NEW APPOINTEE OR STUDENT TRAINEE</b> <table border="1" style="width: 100%; border-collapse: collapse;"><tr><td style="width: 50%; text-align: center;"><input type="checkbox"/> YES</td><td style="width: 50%; text-align: center;"><input type="checkbox"/> NO</td></tr></table>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>E. REPORT DATE TO NEW OR FIRST PERMANENT DUTY STATION (PDS)</b> <i>(YYYYMMDD)</i>			
<input type="checkbox"/> YES	<input type="checkbox"/> NO						
<b>F. LAST PDS LOCATION</b>		<b>G. ACTUAL RESIDENCE AT TIME OF APPOINTMENT</b> <i>(To be determined at time of initial agreement)</i>					

1. 5 U.S.C. §5722 and §5723, provide, under certain conditions, for travel and transportation expenses of the employee (including new appointees or student trainees eligible for first PDS travel), appropriate allowances for the employee's immediate family, movement and storage of household goods (HHG) and personal effects, and certain other allowances incident to an appointment or transfer to an OCONUS location, except movement and storage of HHG is not allowed for round-trip renewal agreement travel. Under the law, the allowances shall not be authorized unless the employee agrees in writing to remain in the Government service for a prescribed period of time. Accordingly, to establish eligibility for the authorized allowances, the following agreement must be executed.

2. I understand and agree that:

a. When I complete \_\_\_\_\_ months, the prescribed tour of duty, I will be eligible for return travel and transportation allowances at Government expense for myself, my dependents, or my household effects, to my actual residence at time of appointment stated above for purpose of separation from the service, unless separated early for reasons beyond my control that are acceptable to the agency concerned.

b. I will remain in Government service for at least 12 months beginning with the effective date of my transfer or appointment to my new OCONUS PDS, unless separated for reasons beyond my control that are acceptable to the agency concerned. If I fail to remain in service the required minimum period of time, or if I am removed for cause before expiration of the required minimum period of service, I am obligated and will, upon demand, repay to the Government a sum of money equivalent to what the Government paid for travel and transportation and related allowances associated with the transfer of myself and my dependents, e.g., HHG storage and shipment, CONUS temporary quarters subsistence expenses, (but not OCONUS temporary quarters subsistence allowance), real estate and/or relocation expenses, miscellaneous expenses, and any other related allowances incident to my transfer, from beginning point of travel to the PDS. The employing Agency may withhold any final pay due to me to apply against or liquidate any indebtedness arising from a violation of this agreement.

3. I understand that the period of service specified above is for the sole purpose of establishing my eligibility for travel and transportation allowances, and other related allowances which may be authorized.

*(Continued on Back)*

<b>H. EMPLOYEE SIGNATURE</b>	<b>I. DATE SIGNED</b> <i>(YYYYMMDD)</i>
------------------------------	---

4. I understand and agree that the address shown above is my actual residence at time of appointment and that it will be used for the purpose of determining transportation entitlement and that this address is not subject to later change for personal reasons.

5. I understand that I may be required to use commercial or Government aircraft for necessary travel to or from my OCONUS PDS unless a medical reason precludes the use of aircraft.

6. I also understand it is neither cost effective nor efficient for DoD to provide more than one PCS move at Government expense during any 12-month period. Accordingly, except as provided in JTR, par. C4100, I am not entitled to any further PCS transfers within DoD, at Government expense, for a period of 12 months from the date of this transfer. This policy does not preclude my acceptance of another position for which PCS expenses may not be allowed.

**NOTE:** Employee should retain a copy of signed transportation agreement for their personal files.

**J. OTHER REMARKS** *(To be completed by personnel office or employing agency officials only.)*

# **RECORD OF EMERGENCY DATA**

## **PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 USC 1475 to 1480 and 2771, 38 USC 1970, 44 USC 3101, and EO 9397, November 1943 (SSN).

**PRINCIPAL PURPOSES:** This form is used to designate beneficiaries for certain benefits in the event of the servicemember's death. It is a guide for the disposition of that member's pay and allowances if captured, missing or interned. It also shows names and addresses of the person(s) the servicemember desires to be notified in case of emergency or death. The purpose of soliciting the SSN is to provide positive identification.

**ROUTINE USES:** None.

**DISCLOSURE:** Voluntary; however, failure to provide personal identifier information may delay notification of the servicemember's status or may handicap processing of benefits to designated beneficiaries.

## **INSTRUCTIONS TO SERVICEMEMBER**

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty, and, to designate beneficiaries for certain benefits if you die. IT IS YOUR RESPONSIBILITY to keep your Record of Emergency Data up to date to show your desires as to beneficiaries to receive certain death payments, and to show changes in your family or other dependents listed; for example, as a result of marriage, civil court action, death, or address change. Regarding your designation in Item 11, "Allotment if Missing" (if used by your Service), please read the following

statement carefully, and sign on the line provided:

I fully understand that, if I am captured, missing, or interned, my designation of allotments to dependents from my pay and allowances serves only as a guide to the Secretary of my Service. The Secretary may alter my designated allotment in the best interests of myself, my dependents, or the United States Government.

*(Signature of Servicemember)*

<b>1. NAME</b> <i>(Last, First, Middle)</i>		<b>2a. SSN</b>	<b>b. INITIAL</b> <i>(To indicate valid SSN)</i>	<b>3a. SERVICE</b>	<b>b. REPORTING UNIT CODE</b> <b>DUTY STATION</b>
<b>4a. SPOUSE NAME</b>		<b>b. ADDRESS</b> <i>(Include ZIP Code)</i>			
<b>5. CHILDREN</b> <b>a. NAME</b>	<b>b. RELATIONSHIP</b>	<b>c. DATE OF BIRTH</b> <i>(YYYYMMDD)</i>	<b>d. ADDRESS</b> <i>(Include ZIP Code)</i>		
<b>6a. FATHER NAME</b>		<b>b. ADDRESS</b> <i>(Include ZIP Code)</i>			
<b>7a. MOTHER NAME</b>		<b>b. ADDRESS</b> <i>(Include ZIP Code)</i>			
<b>8a. DO NOT NOTIFY DUE TO ILL HEALTH</b>		<b>b. NOTIFY INSTEAD</b>			
<b>9a. BENEFICIARY(IES) FOR DEATH GRATUITY</b> <i>(If no surviving spouse or child)</i>		<b>b. ADDRESS</b> <i>(Include ZIP Code)</i>			<b>c. PERCENTAGE</b>
<b>10a. BENEFICIARY(IES) FOR UNPAID PAY/ ALLOWANCES</b>		<b>b. ADDRESS</b> <i>(Include ZIP Code)</i>			<b>c. PERCENTAGE</b>
<b>11. ALLOTMENT DESIGNEE/PERCENTAGE IF MISSING</b> <i>(Subject to Secretarial determination)</i>					
<b>12. INSURANCE</b> <i>(SGLI and other Insurance Companies/Policy Numbers)</i>		<b>a. SGLI</b> <i>(Optional Service Use)</i> <input type="checkbox"/> <b>MAXIMUM</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>OTHER</b> <i>(Amount)</i> _____		<b>b. INSURANCE COMPANIES/POLICY NUMBERS</b>	
<b>13. CONTINUATION/REMARKS</b>					
<b>14. SIGNATURE OF SERVICEMEMBER</b> <i>(Include rank, rate, or grade)</i>		<b>15. SIGNATURE OF WITNESS</b> <i>(Include rank, rate, or grade)</i>		<b>16. DATE SIGNED</b> <i>(YYYYMMDD)</i>	

## INSTRUCTIONS FOR PREPARING DD FORM 93

(See appropriate Service Directives for supplemental instructions for completion of this form at other than MEPS)

All entries explained below are for electronic or typewriter completion, except those specifically noted. If computer or typewriter is not available, print in black or blue-black ink insuring a legible image on all copies. Include "Jr.," "Sr.," "III" or similar designation for each name, if applicable. When an address is entered, include the appropriate ZIP code. If the member cannot provide a current address, indicate "unknown" in the appropriate item. Addresses shown as P.O. Box Numbers or RFD numbers should indicate in Item 13, "Continuations", a street address or general guidance to reach the place of residence. In addition, the notation "See Item 13" should be included in the item pertaining to the particular next of kin. If the address for the person in the item has been shown in a preceding item, it is unnecessary to repeat the address; however, the name must be entered. When the space for a particular item is insufficient, insert "See #13" and continue the information in Item 13. Also see preparation instructions for Item 13.

ITEM 1. Member's full last name, first name, middle name.

ITEM 2a. Member's social security number (SSN).

ITEM 2b. Member's initials in ink, verifying SSN accuracy.

ITEM 3a. Service. Use standard one-letter Service code (A - Army, F - Air Force, N - Navy, M - Marine Corps).

ITEM 3b. Reporting Unit Code/Duty Station. Army/Air Force/Navy - see Service Directives. Marine Corps - MEPS enters Monitored Command Code (MCC) to which the member will be assigned.

ITEM 4. First name, middle initial, maiden name (if applicable), and address of spouse. If member is single, divorced, or widowed, so state.

ITEM 5. First name, middle initial, last name (only if different from member's), relationship to member, and date of birth of all children. If none, so state. Include illegitimate children if acknowledged by member or paternity/maternity has been judicially decreed. Indicate relationship, for example: 03 - son, 04 - daughter, 13 - stepson, 14 - stepdaughter, 33 - adopted daughter, 34 - adopted son. Sample entries: Mary A./04/19650704; Donald E. Jones/13/19630102. For children not living with the member's current spouse, include address and name and relationship of person with whom residing.

ITEM 6. First name, middle initial, last name, and address of father. If unknown or deceased, so state. Include civilian title or military grade if applicable. If other than natural father is listed, indicate relationship.

ITEM 7. First name, middle initial, last name, and address of mother. If unknown or deceased, so state. Include civilian title or military grade if applicable. If other than natural mother is listed, indicate relationship.

ITEM 8. Persons not to be notified due to ill health.

a. List relationship, e.g., "Mother," of person(s) listed in Items 4, 5, 6, or 7 who are not to be notified of a casualty due to ill health. If more than one child, specify, e.g., "daughter Susan."

b. List relationship, e.g., "Father" or name and address of person(s) to be notified in lieu of person(s) listed in item 8a.

ITEM 9a. Enter first name(s), middle initial, last name(s) and relationship of person to receive the 6 months' gratuity pay if there is no surviving spouse or child at the time of death. Only parents (including a person in loco parentis status) and brothers and sisters (including those of half-blood and those through adoption) may be designated. Loco Parentis means any person(s) who acted in place of the member's parent(s) for a period of not less than one year at any time before the member entered on active duty. If brothers or sisters are designated, show date of birth (YYYYMMDD). Enter "None" if the member has no eligible beneficiary. No benefit can be paid in that instance (10 USC 1477). Also enter "None" if the member does not wish to designate a beneficiary. Payment is then made in the order of precedence established by law. The member should make specific designations, as it expedites payment.

ITEM 9b. Enter beneficiary(ies) full mailing address to include the ZIP Code.

ITEM 9c. Show the percentage to be paid to each person if two or more beneficiaries are designated. The sum shares must equal 100 percent. If no percent is indicated and more than one person is named, the money is paid in equal shares to the persons named.

ITEM 10a. Enter first name(s), middle initial, last name(s) and relationship of person to receive unpaid pay and allowances at the time of death. The member may indicate anyone to receive this payment. If the member designated two or more beneficiaries, state the percentage to be paid each in item 10c. If the member does not wish to designate a beneficiary, enter "None." The member is urged to designate a beneficiary for unpaid pay and allowances as payment will be made to the person in order of precedence by law (10 USC 2271) in the absence of a designation.

ITEM 10b. Enter beneficiary(ies) full mailing address to include the ZIP Code.

ITEM 10c. If the member designated two or more beneficiaries, state the percentage to be paid each in this section. The sum shares must equal 100 percent.

ITEM 11. First name, middle initial, last name, relationship, and address of dependent(s) the member designates to receive an allotment of pay if missing, captured, or interned. This allotment may be initiated by the Service Secretary or his designee in the event the member enters a missing status. This item may be left blank. If member designates two or more allottees, state the percentage to be paid to each. The sum shares need not equal 100 percent, but may not exceed 100 percent. NOTE: Designations made in Item 11 are used as a guide by the Service Secretary or designee in establishing, changing, or discontinuing an allotment in the interest of the member (37 USC 551-558). The final decision rests with the Service Secretary or designee.

ITEM 12. Insurance information.

a. Serviceman's Group Life Insurance (SGLI). Not applicable for Marine Corps and Air Force members. NOTE: Completion of this item does not constitute a SGLI election or designation or beneficiary(ies). Indicate, by entering an "X" in the appropriate block, the member's SGLI election (as stated in VA Form 29-8286). For Navy members, on the next line, enter, as appropriate, either: "Bene Desig filed (YYYYMMDD)," or "Bene Desig not filed."

b. Insurance companies/policy numbers. Enter full name of all commercial life insurance companies to be notified in case of death. Enter policy number if member desires; this expedites settlement of claims.

ITEM 13. Continuations/remarks. Use this item for remarks or continuation of other items, if necessary. Prefix entry with the number of the item being continued; for example, 5/John J./03/19451220/321 Pecan Drive, Schertz TX 78151. Also use this item to list name, address, and relationship of other persons the member desires to be notified. Other dependents may also be listed.

ITEM 14. Member's signature. Have the member check and verify all entries and sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade.

ITEM 15. Signature of witness. Have a witness (disinterested person) sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade.

ITEM 16. Date the member signs the form. This item is an ink entry and must be completed by the member on four copies.

## EMPLOYEE EDUCATIONAL DATA

**PRIVACY ACT NOTICE:** In accordance with the provisions of the Privacy Act of 1974 protecting against unwarranted invasion of individual privacy, this information is not to be reproduced or used for any other purpose and will be adequately protected under lock and key while it is in the recipient's custody. It will be disposed of by burning, shredding, or pulping in such a manner that the above intent is carried out.

**INSTRUCTIONS:** Please complete **all** blocks on form **unless** High School is the highest education completed. If High School is the highest, **only** complete blocks 1, 5 and 8. In order to keep your education record up-to-date, be sure to notify the personnel office whenever you attain a higher level of education than the level you previously submitted.

LAST NAME, FIRST NAME, MIDDLE INITIAL OF EMPLOYEE		SSN	ORGANIZATION		
<b>1)</b> Insert the code in the box to the right which best represents the <b>HIGHEST</b> level of education you have attained.			EDUCATION CODE		
<b>2)</b> Instructional Program Studied		<b>3)</b> Total Number of Hours (four digits)			
<b>4)</b> Type of Credit Hours 1=semester 2=quarter		<b>5)</b> TYPE OF SCHOOL (B) Junior College (C) College or University (H) High School (S) Secretarial or Business (W) Vocational			
<b>6)</b> Major or Minor in Program Studied 1= Major (20 semester / 30 quarter or greater) 2= Minor		<b>7)</b> Name of academic institution where degree, certificate, or training received			
<b>8)</b> Insert in the box to the right the last two numbers in the year you attained your <b>highest</b> level of education					

**For EDUCATIONAL CODES please see reverse side!**

**Note: If education level is higher than high school and all blocks are not complete, your education level will be defaulted with high school.**

CODES	EDUCATION LEVEL	DEFINITION
00	NOT APPLICABLE	
01	No formal education or some elementary school, incomplete	Grades 1-8 or equivalent not completed
02	Elementary completed, no high school	Grade 8 or equivalent completed
03	Some high school, not completed	Grades 9-12
04	High School graduate or GED	
05	Terminal occupation program incomplete	Program extending beyond grade 12
06	Terminal occupation program-certificate of completion, diploma	Two levels are recognized: a. Technical/Semiprofessional b. Craftsman/Clerical
07	Some college, less than 1 year	Less than <b>30</b> semester hours or <b>45</b> quarter hours
08	1 Year college	<b>30-59</b> semester hours or <b>45-89</b> quarter hours
09	2 Years college	<b>60-89</b> semester hours or <b>90-134</b> quarter hours
10	Associates degree	2 year college degree
11	3 Years college	<b>90-119</b> semester hours or <b>135-179</b> quarter hours
12	4 Years college	<b>120</b> or more semester hours or <b>180</b> or more quarter hours no bachelor's degree
13	Bachelor's degree	Requires completion of at least 4, but no more than 5 years of academic work; includes bachelor's degree conferred in cooperative plan or program
14	Post bachelor's	Work beyond bachelor's degree but no additional higher degree
15	First professional degree	Completion of academic requirements for selected professions, which are based on programs requiring at least 2 academic years of previous college work for the entrance and a total of at least 6 academic years of college work
16	Post-first Professional	Work beyond the first professional degree but no additional higher degree
17	Master's degree	For liberal arts and sciences, granted upon completion of 1 or 2 academic years beyond bachelor's degree
18	Post master's	Work beyond master's degree, but no additional higher degree
19	Sixth-year	Advanced Certificate in Education Advanced Master of Education Advanced Specialist in Education Certificate of Advanced Study, Advanced degree in Education, Specialist in Education, Licentiate in Philosophy, Specialist in Guidance Counseling, Specialist in Art, Specialist in Science, Specialist in School Administration, Specialist in School Psychology, Licentiate in Sacred Theology
20	Post-sixth year	Work beyond the sixth year degree, but no additional higher degree
21	Doctorate Degree	Includes such degrees as Doctor of Education, Doctor of Juridical Science, Doctor of Public Health, and the Ph.D. in any field
22	Post-doctorate	Work beyond the doctorate

**SIGNATURE**\_\_\_\_\_ **DATE**\_\_\_\_\_



## Questionnaire for Living Quarters Allowance (LQA)

### **CPAC Representative:**

Title and grade of position offered:

Location of position:

RPA Number:

Hard To Fill position?: Yes ☐ No ☐

(Please review Hard-to-Fill List under "H" of Master Index: <http://www.chrma.hqusareur.army.mil/>)

**The information you provide in this questionnaire will be used to determine your eligibility for Living Quarters Allowance (LQA). Please complete one of the sections that applies to you.**

### **Section A. CONTINENTAL UNITED STATES (CONUS) HIRE**

1. Have you physically lived in the United States or a US territory, possession or protectorate for at least 12 months **immediately** prior to receiving this job offer. Yes ☐ No ☐

2. The residences where I have physically lived for the last 12 months are:

FROM (mm/dd/yy)	TO (mm/dd/yy)	ADDRESS

3. My last two employers (if applicable):

FROM (mm/dd/yy)	TO (mm/dd/yy)	EMPLOYER NAME/ADDRESS (City & State)

### **Section B. TRANSFER FROM ANOTHER OVERSEAS ACTIVITY/AGENCY**

1. I am transferring from another government agency, was originally recruited or hired from CONUS, and I am currently an LQA recipient. Yes ☐ No ☐

2. Government agency that originally hired me:

3. Date I originally arrived overseas:

4. City and State from which I transferred:

### Section C. LOCAL HIRE HARD-TO-FILL POSITION

Please check all applicable statements:

- ☐ Military Separation - European out  
☐ Civilian Employee - PCS'd from CONUS  
☐ Contractor  
☐ Other Explain:

☐ **And** I have a current and valid transportation entitlement.

### Section D. TEMPORARY ACTIVE DUTY MILITARY RESERVE STATUS

I am temporarily on Active Duty Military Reserve Status in the overseas area.

Yes ☐ No ☐

### Section E. SELECTEE CERTIFICATION & CONTACT INFORMATION

I understand I may be required to provide substantiating documentation to verify any/all of the information provided above. If such documentation is needed, I can be reached by email or at the following phone numbers during times indicated:

Full Name:			Time Zone
Daytime Phone:		Hours:	
Evening Phone:		Hours:	

**Certification:** The information provided in this statement is true and correct to the best of my knowledge and belief. I understand that if I provide false information I will be required to reimburse the government for any amount I may have received; that I will be subject to disciplinary action that may result in termination of my employment; and that I may be subject to criminal action. (Initials).

This completed questionnaire should be forwarded to (Identify designated CPAC e-mail address) or faxed Overseas to DSN ..... (Identify CPAC DSN) or Commercial .....(Identify CPAC commercial telephone number) within 4 days. Supporting documents must be submitted upon request (via fax) to fax listed above.

**NOTICE OF NON-TEMPORARY STORAGE**

NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

ORGANIZATION ADDRESS:

\_\_\_\_\_

MAILING

ADDRESS: \_\_\_\_\_

TRANSPORTATION OFFICE THAT PROCESSED NTS SHIPMENT:

\_\_\_\_\_

ENTRANCE ON DUTY: \_\_\_\_\_ DUTY PHONE: \_\_\_\_\_

Subject: Request for Identification (ID) Card(s)

Request preparation of DD Form 1172 (Application for Uniformed Services Identification Card DEERS Enrollment) for the following individual(s). The reason(s) for needing ID cards is provided below. I also understand that I must provide the required documentation listed below when I pick up the completed DD Form 1172 from the CPAC, even if I provided documentation in the past.

Reason: \_\_\_\_\_  
Initial, Renewal, Lost or Destroyed (provide date, time & location), Other (specify)

<b>Individual Information</b>	<b><u>Sponsor</u></b>	<b><u>Spouse/First Family Member</u></b>
Name (Last, First, MI. ):	_____	_____
Sex (Female-F/Male-M):	_____	_____
Relationship (2 character code):	(family members only)	_____
Social Security Number:	_____	_____
Status (CIV or RET Civ & Mil):	_____	_____
Civ Pay Plan/Grade (e.g.WG5/GS11):	_____	_____
Ret Mil Br Of Svc (USA/USAF/Navy):	_____	_____
Ret Mil Pay Grade (E8/W3/04):	_____	_____
Ret Mil Rank (MSG/CWO-3/LCDR):	_____	_____
Unit (Include CMR/Unit # & APO #):	_____	_____
Duty Telephone Number (DSN):	_____	_____
DOB (yyyymmdd/e.g.: 1951Aug09):	_____	_____
Color Of Eyes (2 character code):	_____	_____
Color Of Hair (2 character code):	_____	_____
Height (Inches/2 characters 5'-6" = 66):	_____	_____
Weight (Lbs./3 characters 90 lbs = 090):	_____	_____
Marital Status (3 character code):	_____	_____
DEROS (yyyymmdd/e.g.: 2004Jun07):	_____	_____
Date Of Marriage (yyyymmdd):	(spouse only)	_____

<b>Individual Information</b>	<b><u>Second Family Member</u></b>	<b><u>Third Family Member</u></b>
Name (Last, First, MI. ):	_____	_____
Sex (Female-F/Male-M):	_____	_____
Relationship (2 character code):	_____	_____
Social Security Number:	_____	_____
DOB (yyyymmdd/e.g.: 1951Aug09):	_____	_____
Color Of Eyes (2 character code):	_____	_____
Color Of Hair (2 character code):	_____	_____
Height (Inches/2 characters 5'-6" = 66):	_____	_____
Weight (Lbs./3 characters 90 lbs = 090):	_____	_____

	<u><b>Fourth Family Member</b></u>	<u><b>Fifth Family Member</b></u>
Name (Last, First, MI. ):	_____	_____
Sex (Female-F/Male-M):	_____	_____
Relationship (2 character code):	_____	_____
Social Security Number:	_____	_____
DOB (yyyymmdd/e.g.: 1951Aug09):	_____	_____
Color Of Eyes (2 character code):	_____	_____
Color Of Hair (2 character code):	_____	_____
Height (Inches/2 characters 5'-6" = 66):	_____	_____
Weight (Lbs./3 characters 90 lbs = 090):	_____	_____

	<u><b>Sixth Family Member</b></u>	<u><b>Seventh Family Member</b></u>
Name (Last, First, MI. ):	_____	_____
Sex (Female-F/Male-M):	_____	_____
Relationship (2 character code):	_____	_____
Social Security Number:	_____	_____
DOB (yyyymmdd/e.g.: 1951Aug09):	_____	_____
Color Of Eyes (2 character code):	_____	_____
Color Of Hair (2 character code):	_____	_____
Height (Inches/2 characters 5'-6" = 66):	_____	_____
Weight (Lbs./3 characters 90 lbs = 090):	_____	_____

<u><b>Marital Status</b></u>		<u><b>Character Codes</b></u>		<u><b>Eye Color</b></u>		<u><b>Hair Color</b></u>	
		<u><b>Relationship</b></u>					
ANL	Annulled	SP	Spouse	BR	Brown	BR	Brown
DIV	Divorced	CH	Child	GR	Green	GY	Gray
INT	Interlocutory Decree	SC	Stepchild	BL	Blue	RD	Red
JSM	Joint Service Marriage	WARD	Legal Ward	HZ	Hazel	AU	Auburn
LSP	Legally Separated	PAR	Parent	BK	Black	BK	Black
MAR	Married	PL	Parent-in-Law	GY	Gray	BN	Blonde
SGL	Single	SPL	Step-Parent-in-Law	OT	Other	OT	Other
WID	Widow or Widower	URW	Unremarried Widow(er) (never remarried)				
		UMW	Unmarried Widow(er)				

#### **Required Documentation**

- DD Form 214 Only if Sponsor or spouse is retired military
- Marriage License Only if renewing ID Card for spouse
- Birth Certificate(s) of Child(ren) Only if renewing ID Card(s) for Child(ren) (Document(s) must prove relationship)
- Birth Certificate(s) of Child(ren) and Marriage Licenses If renewing ID Card(s) for Step-children (Document(s) must prove relationship)
- College/Univ. Letter verifying full time enrollment Only if renewing ID Card(s) for Child(ren) over 21 years of age.
- Other as requested by verifying official.

## **CHANGE OF ADDRESS FORM**

### **FOR USAREUR SERVICED ACTIVITIES**

The information below is requested to update your personnel and pay records (Leave and Earning Statement (LES) and payroll deducted bonds) with your new mailing address. **Mail or return this form to your servicing Civilian Personnel Advisory Center.**

Name (Print Full Name):

\_\_\_\_\_  
Last First MI

Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ I request that my mailing address for my Leave and Earnings Statement (LES) be changed.

\_\_\_\_\_ I request that my mailing address for my bond(s) be changed.

I request this change to be effective on \_\_\_\_\_.

#### **Old Address**

#### **New Address** **(Must be US Mailing Address)**

1st Line: \_\_\_\_\_

1st Line: \_\_\_\_\_

2nd Line: \_\_\_\_\_

2nd Line: \_\_\_\_\_

City: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE OF EMPLOYEE**

\_\_\_\_\_  
**DATE**

This form is subject to the Privacy Act of 1974 (5 USC 552a). The information requested will be used to update your records with your U.S. mailing address. Furnishing all requested information will expedite the process of updating your records. The effects of not providing all or part of the requested information may delay your receipt of applicable documents.



# Employee Health Benefits Election Form

## Uses for Standard Form (SF) 2809

### Use this form to:

- Enroll in the FEHB Program; or
- Elect not to enroll in the FEHB Program (employees only); or
- Change your FEHB enrollment from Self Only to Self and Family and/or from your present plan or option to another plan or option because of an event described in the table beginning on page 6; or
- Change your FEHB enrollment from Self and Family to Self Only; or
- Cancel your FEHB enrollment.

## Who May Use SF 2809

1. Employees eligible to enroll in or currently enrolled in the FEHB Program, including temporary employees eligible under 5 U.S.C. 8906a.

**Note:** *Civil Service Retirement System (CSRS) and Federal Employees Retirement System (FERS) annuitants and former spouses and children of CSRS/FERS annuitants -- Do not use this form. Instead, call the Retirement Information Office toll-free at 1-888-767-6738. Customers within the local calling distance to Washington, DC, should call 202-606-0500.*

2. Former spouses eligible to enroll in or currently enrolled in the FEHB Program under the Spouse Equity law or similar statutes.
3. Individuals eligible for temporary continuation of coverage under the FEHB Program, including:
  - Former employees (who separated from service);
  - Children who lose FEHB coverage; and
  - Former spouses who are not eligible for FEHB under item 2 above.

## Instructions for Completing SF 2809

### Type or Print Firmly

#### Part A. You must complete this part.

- Item 1. Give your last name, first name and middle initial.
- Item 2. Enter your Social Security Number. (See the Privacy Act and Public Burden Statements on page 5.)
- Item 3. Give your date of birth, using numbers to show the month, day, and complete year; e.g., 06/30/1998.
- Item 4. Enter your permanent home mailing address.

- Item 5. Place an "X" in the appropriate box.
- Item 6. Place an "X" in the box that signifies your current marital status (if you are separated but not divorced, you are still married).
- Item 7. Give the telephone number where you can be reached during normal business hours. Be sure to include the area code.

#### Part B. Complete this part to enroll or change your enrollment in the FEHB Program.

- Item 1. Enter the plan name and appropriate enrollment code from the front cover of the brochure of the plan you want to be enrolled in. The enrollment code shows the plan and option you are electing and whether you are enrolling for Self Only or Self and Family.

To enroll in a Health Maintenance Organization (HMO), you must live (or in some cases work) in a geographic area specified by the carrier.

To enroll in an employee organization plan, you must be or become a member of the plan's sponsoring organization, as specified by the carrier.

Your signature in Part G authorizes deductions from your salary, annuity, or compensation to cover your cost of the enrollment you elect in this item, unless you are required to make direct payments to the employing office.

### Items 2a through 2f

Complete these items only if your enrollment is for Self and Family. (If you need extra space for additional family members, list them on a separate sheet and attach.)

- Item 2a. Indicate the first name and middle initial of each covered family member. Also, give the last name if different from your own.
- Item 2b. Provide the ZIP code if it is different from the enrollee's ZIP code in Part A, item 4.
- Item 2c. Give each dependent's date of birth, using numbers to show the month, day, and complete year; e.g., 06/30/1998.
- Item 2d. Indicate *M* for male or *F* for female.
- Item 2e. Provide the code which indicates the relationship of each eligible family member to you.
  1. Spouse
  2. Unmarried dependent child under age 22 (including an adopted child)

3. Stepchild, foster child, or recognized child born out of wedlock
4. Unmarried disabled child over age 22 incapable of self support because of a physical or mental disability that began before age 22.

Item 2f. Please provide Social Security Numbers for your dependents if available. If not available, leave blank; benefits will not be withheld. (See Privacy Act Statement on page 5.)

### Family Members Eligible for Coverage

Unless you are a former spouse or survivor annuitant, family members eligible for coverage under your Self and Family enrollment include your spouse and your unmarried dependent children under age 22. Eligible children include your legitimate or adopted children; and recognized children born out of wedlock, stepchildren or foster children, if they live with you in a regular parent-child relationship. A recognized child born out of wedlock also may be included if a judicial determination of support has been obtained or you show that you provide regular and substantial support for the child.

Other relatives (for example, your parents) are **not** eligible for coverage even if they live with you and are dependent upon you.

If you are a former spouse or survivor annuitant, family members eligible for coverage under your Self and Family enrollment are the unmarried dependent natural or adopted children under age 22 of both you and your former or deceased spouse.

Children whose marriage ends before they reach age 22 become eligible for coverage under your Self and Family enrollment from the date the marriage ends until they reach age 22.

In some cases, an unmarried, disabled child who is 22 years old or older is eligible for coverage under your Self and Family enrollment if you provide adequate medical certification of a mental or physical handicap that existed before his or her 22nd birthday and renders the child incapable of self-support.

**Note:** Your employing office (see definition under *Where to Obtain FEHB Guides and Brochures* on page 3) can give you additional details about family member eligibility including the documentation required for coverage of a disabled child age 22 or older.

Item 3a. Place an "X" in the appropriate box. If you answer "Yes," enter the name of the policyholder in the space provided and complete item 3b.

Item 3b. If you or your spouse has Medicare, check the Medicare box and show which Parts each of you have.

If you or any covered family member has TRICARE (including CHAMPUS), check that box.

If you or any covered family member has any other group insurance, check that box and give the name of the insurance.

**Part C.** You must complete this part if you are changing your enrollment.

Item 1. Enter the name of the plan you are in now.

Item 2. Enter your present enrollment code.

**Part D.** You must complete this part if you are newly enrolling or changing based on an event listed in the Table of Permissible Changes in Enrollment beginning on page 6. Do not complete this part if you are cancelling or changing from Self and Family to Self Only.

Item 1. Enter the event code that permits you to enroll or change, from the table beginning on page 6.

Item 2. Enter the date of the event that permits you to enroll or change, using numbers to show month, day, and complete year; e.g., 06/30/1998. For initial enrollment, enter the date you became eligible to enroll (for example, the date your appointment began). For Open Season changes, enter the date on which the Open Season begins.

**Part E.** Place an "X" in the box provided only if you are an employee and you do not wish to enroll in the FEHB Program. **(Be sure to read the information about electing not to enroll on page 4.)**

**Part F.** Place an "X" in the box provided only if you wish to cancel your FEHB enrollment. Also enter your present enrollment code in the space provided. **(Be sure to read the information about cancelling your enrollment on page 4.)**

**Part G.** You must complete this part.

Item 1. Sign your name. Do not print.

Item 2. Enter the date you sign, using numbers to show the month, day and complete year; e.g., 06/30/1998.

Leave **Part H** and **Remarks** section blank. They are for agency use only.

### If You Are Registering for Someone Else

If you are registering for someone else under a written authorization from him or her to do so, sign your name in Part G and attach the written authorization.

If you are registering for a former spouse eligible for coverage under the Spouse Equity provisions or for an individual eligible for temporary continuation of coverage as his or her court-appointed guardian, sign your name in Part G and attach evidence of your court-appointed guardianship.

## ***Guides to Federal Employees Health Benefits Plans (FEHB Guides) and Plan Brochures***

**FEHB Guides** contain enrollment, plan, and rate information. Be sure you have the correct guide for your enrollment category since more than one guide is issued. The different categories are:

- Employees, non-Postal or Postal
- Annuitants in CSRS or FERS or other retirement systems
- Temporary Continuation of Coverage enrollees and former spouses under Spouse Equity
- Individuals receiving compensation from the Office of Workers' Compensation Programs
- Temporary employees eligible for FEHB under 5 U.S.C. 8906a
- Visually impaired employees

**FEHB Plan brochures** contain detailed information about plan benefits and the contractual description of coverage.

### ***Where to Obtain FEHB Guides and Brochures***

Your plan will send you its brochure before the beginning of each contract year.

FEHB Guides and plan brochures are available from your employing office.

"Employing office" means the office of an agency or retirement system that is responsible for health benefits actions for an employee, annuitant, former spouse eligible for coverage under the Spouse Equity provisions, or individual eligible for temporary continuation of coverage (TCC).

You can also get copies of plan brochures by contacting the plans directly at the telephone numbers shown in the FEHB Guide. The FEHB Guide also shows which plans have their own website.

The FEHB Guide, plan brochures, and other information, including links to plan websites, are available on the World Wide Web. Visit our website at <http://www.opm.gov/insure>.

### ***Employee Express***

Employee Express is an automated system that allows some Federal employees to make changes using a touch-tone telephone, a personal computer or computer kiosk instead of a form. If you are not sure whether you can use Employee Express, call your employing office.

## ***Dual Enrollment***

Normally, you are not eligible to enroll if you are covered as a family member under someone else's enrollment in the FEHB Program. However, such dual enrollments may be permitted under certain circumstances in order to:

- Protect the interests of children who otherwise would lose coverage as family members, or
- Enable an employee who is under age 22 and covered under a parent's enrollment and becomes the parent of a child to enroll for Self and Family coverage.

No person (enrollee or family member) is entitled to receive benefits under more than one enrollment in the Program. (Each enrollee must notify his or her plan of the names of the persons to be covered under his or her enrollment who are not covered under the other enrollment.)

### ***Temporary Continuation of Coverage (TCC)***

While the employing office notifies a former employee of his or her eligibility for temporary continuation of coverage, the employing office must be notified when a child or former spouse becomes eligible.

For the eligible child of an enrollee, the enrollee must notify the employing office within 60 days after the qualifying event occurs; e.g., child reaches age 22.

For the eligible former spouse of an enrollee, the enrollee or the former spouse must notify the employing office within 60 days after the former spouse's change in status; e.g., the date of the divorce.

An individual eligible for temporary continuation of coverage who wants to continue FEHB coverage may choose any plan (for which he or she is eligible), option, and type of enrollment. The time limits for a former employee, child, or former spouse to file the SF 2809 with the employing office appear in event number 4A in the table on page 8.

**Note:** *If someone other than the enrollee notifies the employing office of the child's eligibility for temporary continuation of coverage within the specified time period, the child's opportunity to file the SF 2809 ends 60 days after the qualifying event. If someone other than the enrollee or the former spouse notifies the employing office of the former spouse's eligibility for continued coverage within the specified time period, the former spouse's opportunity to file the SF 2809 ends 60 days after the change in status.*

### ***Effective Dates***

Except for open season, most enrollments and changes of enrollments are effective on the first day of the pay period after the employing office receives the SF 2809 or other appropriate request. Your employing office can give you the specific date on which your enrollment or enrollment change will take effect.

**Note 1:** If you are changing your enrollment from Self and Family to Self Only so that your spouse can enroll for Self Only, you should coordinate the effective date of your spouse's enrollment with the effective date of your enrollment change to avoid a gap in your spouse's coverage.

**Note 2:** If you are cancelling your enrollment and intend to be covered under someone else's enrollment at the time you cancel, you should coordinate the effective date of your cancellation with the effective date of your new coverage to avoid a gap in your coverage.

### ***Cancellation of Enrollment***

You may cancel your enrollment at any time. (If you are a United States Postal Service employee, consult your employing office or information provided by your agency.) However, if you cancel, neither you nor any family member covered by your enrollment are entitled to a 31-day temporary extension of coverage, or to convert to an individual, nongroup policy. Moreover, family members who lose coverage because of your cancellation are not eligible for temporary continuation of coverage. (Be sure to read the additional information below about cancelling your enrollment.)

### ***Employees Who Elect Not to Enroll or Who Cancel Their Enrollment***

To be eligible for an FEHB enrollment after you retire, you must retire:

Under a retirement system for Federal civilian employees, and

On an immediate annuity.

In addition, you must be currently enrolled in a plan under the FEHB Program and must have been enrolled (or covered as a family member) in a plan under the Program for:

The 5 years of service immediately before retirement (i.e., commencing date of annuity entitlement), or

If fewer than 5 years, all service since your first opportunity to enroll. (Generally, your first opportunity to enroll is within 60 days after your first appointment [in your Federal career] to a position under which you are eligible to enroll under conditions that permit a Government contribution toward the enrollment.)

If you do not enroll at your first opportunity or if you cancel your enrollment, you may later enroll or reenroll only under the circumstances explained in the table beginning on page 6. Some employees delay their enrollment or reenrollment until they are nearing 5 years before retirement in order to qualify for FEHB coverage as a retiree; however, there is always the risk that they will retire earlier than expected and not be able to meet the 5-year requirement for continuing FEHB coverage into retirement. Please understand that when you elect not to enroll or cancel your enrollment **you are voluntarily accepting this risk**. An alternative would be to enroll in or change to a lower cost plan so that you meet the requirements for continuation of your FEHB enrollment after retirement.

**Note for temporary employees eligible for FEHB under 5 U.S.C. 8906a:** Your decision not to enroll or to cancel your enrollment will **not** affect your future eligibility to continue FEHB enrollment after retirement.

### ***Annuityants Who Cancel Their Enrollment***

Generally, you cannot reenroll as an annuitant unless you are continuously covered as a family member under another person's enrollment in the FEHB Program during the period between your cancellation and reenrollment. Your employing office can advise you on events that allow eligible annuitants to reenroll.

If you cancel your enrollment because you are covered under another FEHB enrollment, you can reenroll from 31 days before through 60 days after you lose that coverage under the other enrollment.

If you cancel your FEHB enrollment because you are enrolling in a Medicare HMO, or Medicaid or similar State-sponsored program, you can reenroll in the FEHB Program if your coverage ends. If your coverage ends **involuntarily**, you can reenroll 31 days before through 60 days after loss of coverage. If your coverage ends **voluntarily** because you disenroll, you can reenroll during the next open season.

**If you cancel your enrollment for any other reason, you cannot later reenroll, and you and any family members covered by your enrollment are not entitled to a 31-day temporary extension of coverage or to convert to an individual policy.**

### ***Former Spouses (Spouse Equity) Who Cancel Their Enrollment***

Generally, if you cancel your enrollment in the FEHB Program, you cannot reenroll as a former spouse. However, if you stop the enrollment because you acquire other FEHB coverage, your right to FEHB coverage under the spouse equity provisions continues. You may reenroll as a former spouse when the other FEHB coverage ends.

If you cancel your enrollment because you are covered under another FEHB enrollment, you can reenroll from 31 days before through 60 days after you lose that coverage under the other enrollment.

If you cancel your FEHB enrollment because you are enrolling in a Medicare HMO, or Medicaid or similar State-sponsored program, you can reenroll in the FEHB Program if your coverage ends. If your coverage ends **involuntarily**, you can reenroll 31 days before through 60 days after loss of coverage. If your coverage ends **voluntarily** because you disenroll, you can reenroll during the next open season.

**If you cancel your enrollment for any other reason, you cannot later reenroll, and you and any family members covered by your enrollment are not entitled to a 31-day temporary extension of coverage or to convert to an individual policy.**

## ***Temporary Continuation of Coverage Enrollees Who Cancel Their Enrollment***

**If you cancel your TCC enrollment, you cannot reenroll.** Your family members who lose coverage because of your cancellation cannot enroll for TCC in their own right nor can they convert to a nongroup policy. However, family members who are Federal employees or annuitants may enroll in the FEHB Program when you cancel your coverage if they are eligible for FEHB coverage in their own right.

**Note 1:** *If you become covered by a regular enrollment in the FEHB Program, either in your own right or under the enrollment of someone else, your TCC enrollment is suspended. You will need to send documentation of the new enrollment to the employing office maintaining your TCC enrollment so that they can stop the TCC enrollment. If your new FEHB coverage stops before the TCC enrollment would have expired, the TCC enrollment can be reinstated for the remainder of the original eligibility period (18 months for separated employees).*

**Note 2:** *Former spouses (spouse equity) and temporary continuation of coverage enrollees who fail to pay their premiums within specified time frames are considered to have voluntarily cancelled their enrollment.*

## ***Explanation of Table of Permissible Changes in Enrollment***

The table on pages 6 through 9 illustrates when an employee, former spouse, or person eligible for TCC may enroll or change enrollment. The table shows those permissible events that are found in the regulations at 5 CFR Part 890.

The table has been organized by enrollee category. Each category is designated by a number, which identifies the enrollee group, as follows:

- 1 Employees
- 3 Former spouses
- 4 TCC enrollees

**Note:** *Category 2 has been reserved for annuitants (other than CSRS/FERS annuitants), including individuals receiving monthly compensation from the Office of Workers' Compensation Programs, who will be using another edition of this form, SF 2809-1.*

Following each number is a letter, which identifies a specific permissible event; for example, the event code "1A" refers to an employee's initial opportunity to enroll.

At Part D of the SF 2809, Health Benefits Election Form, you must designate your two-character event code (for example, 1A) and the date of the event using numbers to show month, day, and complete year; e.g., 06/30/1998.

## ***Privacy Act Statement***

The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program under Chapter 89, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may (1) identify your enrollment in the plan, (2) verify your and/or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant, or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or social security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency.

While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment.

We request that you provide your Social Security Number so that it may be used as your individual identifier in the Federal Employees Health Benefits Program. Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal government furnish a Social Security Number or tax identification number. This is an amendment to title 31, Section 7701. Failure to furnish the requested information may result in OPM's inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies.

Agencies other than the Office of Personnel Management may have further routine uses for disclosure of information from the records system in which they file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

## ***Public Burden Statement***

We think this form takes an average of 30 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, Reports and Forms Manager, (3206-0160), Washington, D.C. 20415-7900. The OMB number, 3206-0160 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

## Table of Permissible Changes in Enrollment for SF 2809

Enrollment May Be Cancelled or Changed From Family to Self Only at Any Time\*

<i>Events That Permit Enrollment or Change</i>		<i>Change Permitted</i>			<i>Time Limits</i>
<i>Code</i>	<i>Event</i>	<i>From Not Enrolled to Enrolled</i>	<i>From Self Only to Self and Family</i>	<i>From One Plan or Option to Another</i>	<i>When You Must File Health Benefits Election Form With Your Employing Office</i>
<b>1 EMPLOYEE</b>					
1A	Initial opportunity to enroll.	Yes	N/A	N/A	Within 60 days after becoming eligible.
1B	Open Season.	Yes	Yes	Yes	As announced by OPM.
1C	Change in family status; for example: marriage, birth or death of family member, adoption, legal separation, or divorce.	Yes	Yes	Yes	From 31 days before through 60 days after event.
1D	Change in employment status; for example: <ul style="list-style-type: none"> <li>• Reemployment after a break in service of more than three days;</li> <li>• Return to pay status following loss of coverage due to expiration of 365 days of LWOP status or termination of coverage during LWOP;</li> <li>• Return to pay sufficient to make withholdings after termination of coverage during a period of insufficient pay;</li> <li>• Restoration to civilian position after serving in uniformed services;</li> <li>• Change from temporary appointment to appointment that entitles employee receipt of Government contribution;</li> <li>• Change to or from part-time career employment.</li> </ul>	Yes	Yes	Yes	Within 60 days of employment status change.
1E	Separation from Federal employment when the employee or employee's spouse is pregnant.	Yes	Yes	Yes	Enrollment or change must occur during final pay period of employment.
1F	Transfer from a post of duty within the United States to a post of duty outside the United States, or reverse.	Yes	Yes	Yes	From 31 days before leaving old post through 60 days after arriving at new post.
1G	Employee or eligible family member loses coverage under FEHB or another group insurance plan; for example: <ul style="list-style-type: none"> <li>• Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to self only of the covering enrollment;</li> <li>• Loss of coverage under another federally-sponsored health benefits program;</li> <li>• Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan;</li> <li>• Loss of coverage under Medicaid or similar State-sponsored program;</li> <li>• Loss of coverage under a non-Federal health plan.</li> </ul>	Yes	Yes	Yes	From 31 days before through 60 days after loss of coverage.
1H	Employee or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.

\* If you are a United States Postal Service employee, these rules may be different. Consult your employing office or information provided by your agency.

<i>Events That Permit Enrollment or Change</i>		<i>Change Permitted</i>			<i>Time Limits</i>
<i>Code</i>	<i>Event</i>	<i>From Not Enrolled to Enrolled</i>	<i>From Self Only to Self and Family</i>	<i>From One Plan or Option to Another</i>	<i>When You Must File Health Benefits Election Form With Your Employing Office</i>
1I	Loss of coverage under a non-Federal group health plan because an employee moves out of the commuting area to accept another position and the employee's non-federally employed spouse terminates employment to accompany the employee.	Yes	Yes	Yes	From 31 days before the employee leaves the commuting area through 180 days after arriving in the new commuting area.
1J	Employee or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside the area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
1K	On becoming eligible for Medicare  (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.
1L	Temporary employee completes one year of continuous service in accordance with 5 U.S.C. Section 8906a.	Yes	N/A	N/A	Within 60 days after becoming eligible.
1M	Salary of temporary employee insufficient to make withholdings for plan in which enrolled.	N/A	No	Yes	Within 60 days after receiving notice from employing office.
<b>3 FORMER SPOUSE UNDER THE SPOUSE EQUITY PROVISIONS</b>					
3A	Initial opportunity to enroll, Former spouse must be eligible to enroll under the authority of the Civil Service Retirement Spouse Equity Act of 1984 (P.L. 98-615), as amended, the Intelligence Authorization Act of 1986 (P.L. 99-569), or the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989 (P.L. 100-204).	Yes	N/A	N/A	Generally, must apply within 60 days after dissolution of marriage. However, if a retiring employee elects to provide a former spouse annuity or insurable interest annuity for the former spouse, the former spouse must apply within 60 days after OPM's notice of eligibility for FEHB. May enroll any time after employing office establishes eligibility.
3B	Open season.	No	Yes*	Yes	As announced by OPM.
3C	Change in family status based on addition of family members who are also eligible family members of the employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after change in family status.
3D	Reenrollment of former spouse who cancelled FEHB enrollment to enroll in a Medicare sponsored Coordinated Care Plan (Medicare HMO), Medicaid, or similar State-sponsored program and who later was <b>involuntarily</b> disenrolled from the Medicare HMO, Medicaid, or similar State-sponsored program.	May Reenroll	N/A	N/A	From 31 days before through 60 days after disenrollment.

\* Former spouse may change to self and family only if family members are also eligible family members of the employee or annuitant.

<i>Events That Permit Enrollment or Change</i>		<i>Change Permitted</i>			<i>Time Limits</i>
<i>Code</i>	<i>Event</i>	<i>From Not Enrolled to Enrolled</i>	<i>From Self Only to Self and Family</i>	<i>From One Plan or Option to Another</i>	<i>When You Must File Health Benefits Election Form With Your Employing Office</i>
3E	Reenrollment of former spouse who cancelled FEHB enrollment to enroll in a Medicare-sponsored Coordinated Care Plan (Medicare HMO), Medicaid, or similar State-sponsored program and who later <b>voluntarily</b> disenrolls from the Medicare-sponsored Coordinated Care Plan (Medicare HMO), Medicaid, or similar State-sponsored program.	May Reenroll	N/A	N/A	During open season.
3F	Former spouse or eligible child loses FEHB coverage due to termination, cancellation, or change to self only of the covering enrollment.	Yes	Yes	Yes	From 31 days before through 60 days after date of loss of coverage.
3G	Enrolled former spouse or eligible child loses coverage under another group insurance plan; for example: <ul style="list-style-type: none"> <li>• Loss of coverage under another federally-sponsored health benefits program;</li> <li>• Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan;</li> <li>• Loss of coverage under Medicaid or similar State-sponsored program (but see 3D and 3E);</li> <li>• Loss of coverage under a non-Federal health plan.</li> </ul>	N/A	Yes	Yes	From 31 days before through 60 days after loss of coverage.
3H	Former spouse or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
3I	Former spouse or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
3J	On becoming eligible for Medicare  (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning the 30th day before becoming eligible for Medicare.
3K	Former spouse's annuity is insufficient to make FEHB withholdings for plan in which enrolled.	No	No	Yes	Retirement System will advise former spouse of options.
<b>4</b>	<b>TEMPORARY CONTINUATION OF COVERAGE (TCC) FOR ELIGIBLE FORMER EMPLOYEES, FORMER SPOUSES, AND CHILDREN.</b>				
4A	Opportunity to enroll for continued coverage under TCC provisions: <ul style="list-style-type: none"> <li>• Former employee</li> <li>• Former spouse</li> <li>• Child who ceases to qualify as a family member</li> </ul>	Yes Yes Yes	Yes N/A N/A	Yes N/A N/A	Within 60 days after the qualifying event, or receiving notice of eligibility, whichever is later.
4B	Open season: <ul style="list-style-type: none"> <li>• Former employee</li> <li>• Former spouse</li> <li>• Child who ceases to qualify as a family member</li> </ul>	No No No	Yes Yes* Yes	Yes Yes Yes	As announced by OPM.

\* Former spouse may change to self and family only if family members are also eligible family members of the employee or annuitant.

<i>Events That Permit Enrollment or Change</i>		<i>Change Permitted</i>			<i>Time Limits</i>
<i>Code</i>	<i>Event</i>	<i>From Not Enrolled to Enrolled</i>	<i>From Self Only to Family</i>	<i>From One Plan or Option to Another</i>	<i>When You Must File Health Benefits Election Form With Your Employing Office</i>
4C	Change in family status (except former spouse); for example, marriage, birth or death of family member, adoption, legal separation, or divorce.	No	Yes	Yes	From 31 days before through 60 days after event.
4D	Change in family status of former spouse, based on addition of family members who are eligible family members of the employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after event.
4E	Reenrollment of a former employee, former spouse, or child whose TCC enrollment was terminated because of other FEHB coverage and who loses the other FEHB coverage before the TCC period of eligibility (18 or 36 months) expires.	May Reenroll	N/A	N/A	From 31 days before through 60 days after the event. Enrollment is retroactive to the date of the loss of the other FEHB coverage.
4F	<p>Enrollee or eligible family member loses coverage under FEHB or another group insurance plan; for example:</p> <ul style="list-style-type: none"> <li>• Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to self only of the covering enrollment (but see event 4E);</li> <li>• Loss of coverage under another federally-sponsored health benefits program;</li> <li>• Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan;</li> <li>• Loss of coverage under Medicaid or similar State-sponsored program;</li> <li>• Loss of coverage under a non-Federal health plan.</li> </ul>	No	Yes	Yes	From 31 days before through 60 days after loss of coverage.
4G	Enrollee or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
4H	Enrollee or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
4I	<p>On becoming eligible for Medicare.</p> <p>(This change may be made only once in a lifetime.)</p>	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.



# Health Benefits Election Form

## Federal Employees Health Benefits Program

For Employees, Former Spouses Under the Spouse Equity Law, and Individuals

### Eligible for Temporary Continuation of Coverage

Form Approved:  
OMB No. 3206-0160

\* Complete Parts A and G, and  
Parts B, C, D, E, and F as applicable.

Do not separate the copies. Your employing office will certify the completed form and return your copy to you.

• Type or print firmly  
• Sign and date in Part

#### Part A - Fill in this part.

1. Name (last, first, middle initial)	2. Social Security Number	3. Date of birth (mm/dd/yyyy)
4. Your home mailing address (include ZIP code)	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Are you now married? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Daytime telephone number (include area code)		

#### Part B - Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.

1. I elect to enroll in a health benefits plan as shown below. (Copy the information requested below from front cover of brochure of the plan you select.)

Name of plan					Enrollment code	
2a. Names of family members (last, first, middle initial)	2b. ZIP code	2c. Date of birth (mm/dd/yyyy)	2d. Sex	2e. Relation- ship "code"	2f. Social Security Number (see instructions)	
3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? <input type="checkbox"/> No <input type="checkbox"/> Yes → Complete 3b					Name of policyholder (last, first, middle initial)	
3b. Type of insurance <input type="checkbox"/> Medicare <input type="checkbox"/> You <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> Your spouse <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> TRICARE (Including CHAMPUS) <input type="checkbox"/> Other (specify name)						

#### Part C - Fill in this part, as well as PART B, to change enrollment.

#### Part D - Event

1. Present Plan name	2. Present Plan enrollment code →	1. Event code that permits change (see Table of Permissible Changes)	2. Date of event that permits change (mm/dd/yyyy)
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#### Part E - Employees Only

#### Part F - Cancellation

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

Place an "X" in the box below if you wish to CANCEL your enrollment.

Present Plan enrollment code			
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☐ I elect not to enroll in the Federal Employees Health Benefits Program.

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown above.

My signature in PART G certifies that I have read and understand the information on page 4 regarding this election.

My signature in PART G certifies that I have read the information in the instructions on page 4 regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

#### Part G - Fill in this part.

**WARNING:** Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature (do not print)	2. Date (mm/dd/yyyy)
----------------------------------	----------------------

#### Part H - To be completed by agency

1. Name and address of employing office (include ZIP code)  -----  -----	2. Date received in employing office (mm/dd/yyyy)	3. Effective date of action (mm/dd/yyyy)	4. SF 2811 report number
	5. Payroll office number	6. Payroll contact and telephone number (including area code) (       )	
	7. Personnel contact and telephone number (including area code) (       )		
	8. Signature of authorized agency official and telephone number (including area code) (       )		

Remarks



# Health Benefits Election Form

## Federal Employees Health Benefits Program

For Employees, Former Spouses Under the Spouse Equity Law, and Individuals

### Eligible for Temporary Continuation of Coverage

Form Approved:  
OMB No. 3206-0160

\* Complete Parts A and G, and  
Parts B, C, D, E, and F as applicable.

Do not separate the copies. Your employing office will certify the completed form and return your copy to you.

• Type or print firmly  
• Sign and date in Part

#### Part A - Fill in this part.

1. Name (last, first, middle initial)	2. Social Security Number	3. Date of birth (mm/dd/yyyy)
4. Your home mailing address (include ZIP code)	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Are you now married? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Daytime telephone number (include area code)		

#### Part B - Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.

1. I elect to enroll in a health benefits plan as shown below. (Copy the information requested below from front cover of brochure of the plan you select.)					
Name of plan					Enrollment code
2a. Names of family members (last, first, middle initial)	2b. ZIP code	2c. Date of birth (mm/dd/yyyy)	2d. Sex	2e. Relationship "code"	2f. Social Security Number (see instructions)
3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? <input type="checkbox"/> No <input type="checkbox"/> Yes → Complete 3b					
Name of policyholder (last, first, middle initial)					
3b. Type of insurance <input type="checkbox"/> Medicare <input type="checkbox"/> You <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> Your spouse <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> TRICARE (Including CHAMPUS) <input type="checkbox"/> Other (specify name)					

#### Part C - Fill in this part, as well as PART B, to change enrollment.

1. Present Plan name	2. Present Plan enrollment code →	1. Event code that permits change (see Table of Permissible Changes)	2. Date of event that permits change (mm/dd/yyyy)
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#### Part E - Employees Only

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

☐ I elect not to enroll in the Federal Employees Health Benefits Program.

My signature in PART G certifies that I have read and understand the information on page 4 regarding this election.

#### Part F - Cancellation

Place an "X" in the box below if you wish to CANCEL your enrollment.

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown above.

My signature in PART G certifies that I have read the information in the instructions on page 4 regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

#### Part G - Fill in this part.

**WARNING:** Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature (do not print)	2. Date (mm/dd/yyyy)
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#### Part H - To be completed by agency

1. Name and address of employing office (include ZIP code)	2. Date received in employing office (mm/dd/yyyy)	3. Effective date of action (mm/dd/yyyy)	4. SF 2811 report number
	5. Payroll office number	6. Payroll contact and telephone number (including area code)	
	7. Personnel contact and telephone number (including area code)		
	8. Signature of authorized agency official and telephone number (including area code)		

Remarks



# Health Benefits Election Form

## Federal Employees Health Benefits Program

For Employees, Former Spouses Under the Spouse Equity Law, and Individuals

### Eligible for Temporary Continuation of Coverage

Form Approved:  
OMB No. 3206-0160

\* Complete Parts A and G, and  
Parts B, C, D, E, and F as applicable.

Do not separate the copies. Your employing office will certify the completed form and return your copy to you.

• Type or print firmly  
• Sign and date in Part

#### Part A - Fill in this part.

1. Name (last, first, middle initial)	2. Social Security Number	3. Date of birth (mm/dd/yyyy)
4. Your home mailing address (include ZIP code)	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Are you now married? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Daytime telephone number (include area code)		

#### Part B - Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.

1. I elect to enroll in a health benefits plan as shown below. (Copy the information requested below from front cover of brochure of the plan you select.)					
Name of plan					Enrollment code
2a. Names of family members (last, first, middle initial)	2b. ZIP code	2c. Date of birth (mm/dd/yyyy)	2d. Sex	2e. Relationship "code"	2f. Social Security Number (see instructions)
3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? <input type="checkbox"/> No <input type="checkbox"/> Yes → Complete 3b					
3b. Type of insurance <input type="checkbox"/> Medicare <input type="checkbox"/> You <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> Your spouse <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> TRICARE (Including CHAMPUS) <input type="checkbox"/> Other (specify name)					

#### Part C - Fill in this part, as well as PART B, to change enrollment.

1. Present Plan name	2. Present Plan enrollment code →	1. Event code that permits change (see Table of Permissible Changes)	2. Date of event that permits change (mm/dd/yyyy)
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#### Part E - Employees Only

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

☐ I elect not to enroll in the Federal Employees Health Benefits Program.

My signature in PART G certifies that I have read and understand the information on page 4 regarding this election.

#### Part F - Cancellation

Place an "X" in the box below if you wish to CANCEL your enrollment.

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown above.

My signature in PART G certifies that I have read the information in the instructions on page 4 regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

#### Part G - Fill in this part.

**WARNING:** Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature (do not print)	2. Date (mm/dd/yyyy)
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#### Part H - To be completed by agency

1. Name and address of employing office (include ZIP code)	2. Date received in employing office (mm/dd/yyyy)	3. Effective date of action (mm/dd/yyyy)	4. SF 2811 report number
	5. Payroll office number	6. Payroll contact and telephone number (including area code)	
	7. Personnel contact and telephone number (including area code)		
	8. Signature of authorized agency official and telephone number (including area code)		

Remarks



# Health Benefits Election Form

## Federal Employees Health Benefits Program

For Employees, Former Spouses Under the Spouse Equity Law, and Individuals

### Eligible for Temporary Continuation of Coverage

Form Approved:  
OMB No. 3206-0160

\* Complete Parts A and G, and  
Parts B, C, D, E, and F as applicable.

Do not separate the copies. Your employing office will certify the completed form and return your copy to you.

• Type or print firmly  
• Sign and date in Part

#### Part A - Fill in this part.

1. Name (last, first, middle initial)	2. Social Security Number	3. Date of birth (mm/dd/yyyy)
4. Your home mailing address (include ZIP code)	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Are you now married? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Daytime telephone number (include area code)		

#### Part B - Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.

1. I elect to enroll in a health benefits plan as shown below. (Copy the information requested below from front cover of brochure of the plan you select.)

Name of plan					Enrollment code			
2a. Names of family members (last, first, middle initial)	2b. ZIP code	2c. Date of birth (mm/dd/yyyy)	2d. Sex	2e. Relation- ship "code"	2f. Social Security Number (see instructions)			
3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled?					Name of policyholder (last, first, middle initial)			
<input type="checkbox"/> No <input type="checkbox"/> Yes → Complete 3b								
3b. Type of insurance <input type="checkbox"/> Medicare <input type="checkbox"/> You <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> Your spouse <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> TRICARE (Including CHAMPUS) <input type="checkbox"/> Other (specify name)								

#### Part C - Fill in this part, as well as PART B, to change enrollment.

#### Part D - Event

1. Present Plan name	2. Present Plan enrollment code →	1. Event code that permits change (see Table of Permissible Changes)	2. Date of event that permits change (mm/dd/yyyy)
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#### Part E - Employees Only

#### Part F - Cancellation

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

Place an "X" in the box below if you wish to CANCEL your enrollment.

Present Plan enrollment code			
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☐ I elect not to enroll in the Federal Employees Health Benefits Program.

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown above.

My signature in PART G certifies that I have read and understand the information on page 4 regarding this election.

My signature in PART G certifies that I have read the information in the instructions on page 4 regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

#### Part G - Fill in this part.

**WARNING:** Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature (do not print)	2. Date (mm/dd/yyyy)
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#### Part H - To be completed by agency

1. Name and address of employing office (include ZIP code)	2. Date received in employing office (mm/dd/yyyy)	3. Effective date of action (mm/dd/yyyy)	4. SF 2811 report number
	5. Payroll office number	6. Payroll contact and telephone number (including area code)	
	7. Personnel contact and telephone number (including area code)		
	8. Signature of authorized agency official and telephone number (including area code)		

Remarks



# Health Benefits Election Form

## Federal Employees Health Benefits Program

For Employees, Former Spouses Under the Spouse Equity Law, and Individuals

### Eligible for Temporary Continuation of Coverage

Form Approved:  
OMB No. 3206-0160

\* Complete Parts A and G, and  
Parts B, C, D, E, and F as applicable.

Do not separate the copies. Your employing office will certify the completed form and return your copy to you.

• Type or print firmly  
• Sign and date in Part

#### Part A - Fill in this part.

1. Name (last, first, middle initial)	2. Social Security Number	3. Date of birth (mm/dd/yyyy)
4. Your home mailing address (include ZIP code)	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Are you now married? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Daytime telephone number (include area code)		

#### Part B - Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.

1. I elect to enroll in a health benefits plan as shown below. (Copy the information requested below from front cover of brochure of the plan you select.)

Name of plan					Enrollment code			
2a. Names of family members (last, first, middle initial)	2b. ZIP code	2c. Date of birth (mm/dd/yyyy)	2d. Sex	2e. Relation- ship "code"	2f. Social Security Number (see instructions)			
3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled?					Name of policyholder (last, first, middle initial)			
<input type="checkbox"/> No <input type="checkbox"/> Yes → Complete 3b								
3b. Type of insurance <input type="checkbox"/> Medicare <input type="checkbox"/> You <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> Your spouse <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> TRICARE (Including CHAMPUS) <input type="checkbox"/> Other (specify name)								

#### Part C - Fill in this part, as well as PART B, to change enrollment.

#### Part D - Event

1. Present Plan name	2. Present Plan enrollment code →	1. Event code that permits change (see Table of Permissible Changes)	2. Date of event that permits change (mm/dd/yyyy)

#### Part E - Employees Only

#### Part F - Cancellation

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

Place an "X" in the box below if you wish to CANCEL your enrollment.

Present Plan enrollment code			
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☐ I elect not to enroll in the Federal Employees Health Benefits Program.

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown above.

My signature in PART G certifies that I have read and understand the information on page 4 regarding this election.

My signature in PART G certifies that I have read the information in the instructions on page 4 regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

#### Part G - Fill in this part.

**WARNING:** Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature (do not print)	2. Date (mm/dd/yyyy)

#### Part H - To be completed by agency

1. Name and address of employing office (include ZIP code)  -----  -----	2. Date received in employing office (mm/dd/yyyy)	3. Effective date of action (mm/dd/yyyy)	4. SF 2811 report number
	5. Payroll office number	6. Payroll contact and telephone number (including area code) ( )	
	7. Personnel contact and telephone number (including area code) ( )		
	8. Signature of authorized agency official and telephone number (including area code) ( )		

Remarks

# Form W-4 (2003)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct Federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

**Exemption from withholding.** If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2003 expires February 16, 2004. See **Pub. 505**, Tax Withholding and Estimated Tax.

**Note:** You cannot claim exemption from withholding if: (a) your income exceeds \$750 and includes more than \$250 of unearned income (e.g., interest and dividends) and (b) another person can claim you as a dependent on their tax return.

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized

deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. **However, you may claim fewer (or zero) allowances.**

**Head of household.** Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line **E** below.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See **Pub. 919**, How Do I Adjust My Tax Withholding? for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using

**Form 1040-ES**, Estimated Tax for Individuals. Otherwise, you may owe additional tax.

**Two earners/two jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

**Nonresident alien.** If you are a nonresident alien, see the **Instructions for Form 8233** before completing this Form W-4.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2003. See Pub. 919, especially if your earnings exceed \$125,000 (Single) or \$175,000 (Married).

**Recent name change?** If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 for a new social security card.

## Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for <b>yourself</b> if no one else can claim you as a dependent . . . . .	A	_____						
B	Enter "1" if: <table><tr><td>• You are single and have only one job; or</td><td rowspan="3">}</td><td rowspan="3">. . . . .</td><td rowspan="3">B _____</td></tr><tr><td>• You are married, have only one job, and your spouse does not work; or</td></tr><tr><td>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less.</td></tr></table>	• You are single and have only one job; or	}	. . . . .	B _____	• You are married, have only one job, and your spouse does not work; or	• Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less.		
• You are single and have only one job; or	}	. . . . .				B _____			
• You are married, have only one job, and your spouse does not work; or									
• Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less.									
C	Enter "1" for your <b>spouse</b> . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . .	C	_____						
D	Enter number of <b>dependents</b> (other than your spouse or yourself) you will claim on your tax return . . . . .	D	_____						
E	Enter "1" if you will file as <b>head of household</b> on your tax return (see conditions under <b>Head of household</b> above) . . . . .	E	_____						
F	Enter "1" if you have at least \$1,500 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . .	F	_____						
<b>(Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)</b>									
G	<b>Child Tax Credit</b> (including additional child tax credit): <ul style="list-style-type: none"><li>• If your total income will be between \$15,000 and \$42,000 (\$20,000 and \$65,000 if married), enter "1" for each eligible child plus <b>1 additional</b> if you have three to five eligible children or <b>2 additional</b> if you have six or more eligible children.</li><li>• If your total income will be between \$42,000 and \$80,000 (\$65,000 and \$115,000 if married), enter "1" if you have one or two eligible children, "2" if you have three eligible children, "3" if you have four eligible children, or "4" if you have five or more eligible children.</li></ul>	G	_____						
H	Add lines A through G and enter total here. <b>Note:</b> This may be different from the number of exemptions you claim on your tax return. ▶	H	_____						
For accuracy, complete all worksheets that apply. <table><tr><td>• If you plan to <b>itemize or claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.</td><td rowspan="3">}</td><td rowspan="3">. . . . .</td><td rowspan="3">H _____</td></tr><tr><td>• If you have <b>more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$35,000, see the <b>Two-Earner/Two-Job Worksheet</b> on page 2 to avoid having too little tax withheld.</td></tr><tr><td>• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.</td></tr></table>				• If you plan to <b>itemize or claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.	}	. . . . .	H _____	• If you have <b>more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$35,000, see the <b>Two-Earner/Two-Job Worksheet</b> on page 2 to avoid having too little tax withheld.	• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.
• If you plan to <b>itemize or claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.	}	. . . . .	H _____						
• If you have <b>more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$35,000, see the <b>Two-Earner/Two-Job Worksheet</b> on page 2 to avoid having too little tax withheld.									
• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.									

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form <b>W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0010 <b>2003</b>	
▶ <b>For Privacy Act and Paperwork Reduction Act Notice, see page 2.</b>					
1 Type or print your first name and middle initial		Last name		2 Your social security number	
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note:</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card. ▶ <input type="checkbox"/>	
City or town, state, and ZIP code		5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____	
		6 Additional amount, if any, you want withheld from each paycheck . . . . .		6 \$ _____	
7 I claim exemption from withholding for 2003, and I certify that I meet <b>both</b> of the following conditions for exemption: <ul style="list-style-type: none"><li>• Last year I had a right to a refund of <b>all</b> Federal income tax withheld because I had <b>no</b> tax liability and</li><li>• This year I expect a refund of <b>all</b> Federal income tax withheld because I expect to have <b>no</b> tax liability.</li></ul> If you meet both conditions, write "Exempt" here . . . . . ▶		7		7 _____	
Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status.					
<b>Employee's signature</b> (Form is not valid unless you sign it.) ▶					
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)		10 Employer identification number	

**Deductions and Adjustments Worksheet**

**Note:** Use this worksheet **only** if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2003 tax return.

- 1 Enter an estimate of your 2003 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2003, you may have to reduce your itemized deductions if your income is over \$139,500 (\$69,750 if married filing separately). See **Worksheet 3** in Pub. 919 for details.) . . . 1 \$ \_\_\_\_\_
- 2 Enter:  $\left\{ \begin{array}{l} \$7,950 \text{ if married filing jointly or qualifying widow(er)} \\ \$7,000 \text{ if head of household} \\ \$4,750 \text{ if single} \\ \$3,975 \text{ if married filing separately} \end{array} \right\}$  . . . . . 2 \$ \_\_\_\_\_
- 3 **Subtract** line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . . . . 3 \$ \_\_\_\_\_
- 4 Enter an estimate of your 2003 adjustments to income, including alimony, deductible IRA contributions, and student loan interest . . . . . 4 \$ \_\_\_\_\_
- 5 **Add** lines 3 and 4 and enter the total. Include any amount for credits from **Worksheet 7** in Pub. 919 . . . . . 5 \$ \_\_\_\_\_
- 6 Enter an estimate of your 2003 nonwage income (such as dividends or interest) . . . . . 6 \$ \_\_\_\_\_
- 7 **Subtract** line 6 from line 5. Enter the result, but not less than "-0-" . . . . . 7 \$ \_\_\_\_\_
- 8 **Divide** the amount on line 7 by \$3,000 and enter the result here. Drop any fraction . . . . . 8 \_\_\_\_\_
- 9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 . . . . . 9 \_\_\_\_\_
- 10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earner/Two-Job Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 . . . . . 10 \_\_\_\_\_

**Two-Earner/Two-Job Worksheet**

**Note:** Use this worksheet **only** if the instructions under line H on page 1 direct you here.

- 1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) . . . . . 1 \_\_\_\_\_
- 2 Find the number in **Table 1** below that applies to the **lowest** paying job and enter it here . . . . . 2 \_\_\_\_\_
- 3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . 3 \_\_\_\_\_

**Note:** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4-9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

- 4 Enter the number from line 2 of this worksheet . . . . . 4 \_\_\_\_\_
- 5 Enter the number from line 1 of this worksheet . . . . . 5 \_\_\_\_\_
- 6 **Subtract** line 5 from line 4 . . . . . 6 \_\_\_\_\_
- 7 Find the amount in **Table 2** below that applies to the **highest** paying job and enter it here . . . . . 7 \$ \_\_\_\_\_
- 8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . . . 8 \$ \_\_\_\_\_
- 9 Divide line 8 by the number of pay periods remaining in 2003. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2002. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . 9 \$ \_\_\_\_\_

**Table 1: Two-Earner/Two-Job Worksheet**

Married Filing Jointly				All Others			
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above
\$0 - \$4,000 . . . . .	0	44,001 - 50,000 . . . . .	8	\$0 - \$6,000 . . . . .	0	75,001 - 100,000 . . . . .	8
4,001 - 9,000 . . . . .	1	50,001 - 60,000 . . . . .	9	6,001 - 11,000 . . . . .	1	100,001 - 110,000 . . . . .	9
9,001 - 15,000 . . . . .	2	60,001 - 70,000 . . . . .	10	11,001 - 18,000 . . . . .	2	110,001 and over . . . . .	10
15,001 - 20,000 . . . . .	3	70,001 - 90,000 . . . . .	11	18,001 - 25,000 . . . . .	3		
20,001 - 25,000 . . . . .	4	90,001 - 100,000 . . . . .	12	25,001 - 29,000 . . . . .	4		
25,001 - 33,000 . . . . .	5	100,001 - 115,000 . . . . .	13	29,001 - 40,000 . . . . .	5		
33,001 - 38,000 . . . . .	6	115,001 - 125,000 . . . . .	14	40,001 - 55,000 . . . . .	6		
38,001 - 44,000 . . . . .	7	125,001 and over . . . . .	15	55,001 - 75,000 . . . . .	7		

**Table 2: Two-Earner/Two-Job Worksheet**

Married Filing Jointly		All Others	
If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$50,000 . . . . .	\$450	\$0 - \$30,000 . . . . .	\$450
50,001 - 100,000 . . . . .	800	30,001 - 70,000 . . . . .	800
100,001 - 150,000 . . . . .	900	70,001 - 140,000 . . . . .	900
150,001 - 270,000 . . . . .	1,050	140,001 - 300,000 . . . . .	1,050
270,001 and over . . . . .	1,200	300,001 and over . . . . .	1,200

**Privacy Act and Paperwork Reduction Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. **Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties.** Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, and the District of Columbia for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to Federal and state agencies to enforce Federal nontax criminal laws and to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB

control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The time needed to complete this form will vary depending on individual circumstances. The estimated average time is: **Recordkeeping**, 46 min.; **Learning about the law or the form**, 13 min.; **Preparing the form**, 59 min. If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Tax Forms Committee, Western Area Distribution Center, Rancho Cordova, CA 95743-0001. **Do not** send the tax form to this address. Instead, give it to your employer.

